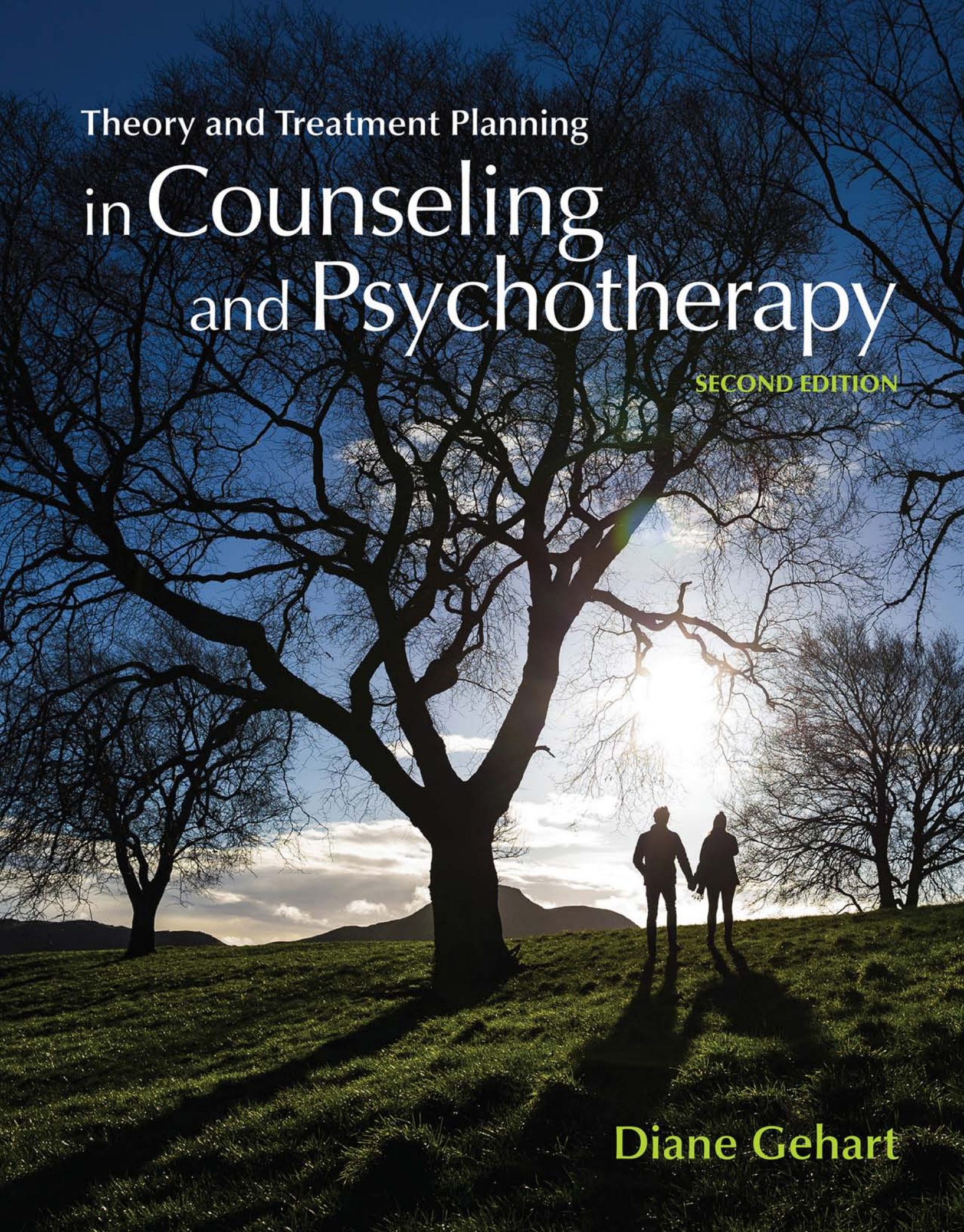
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in Counseling
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SECOND EDITION
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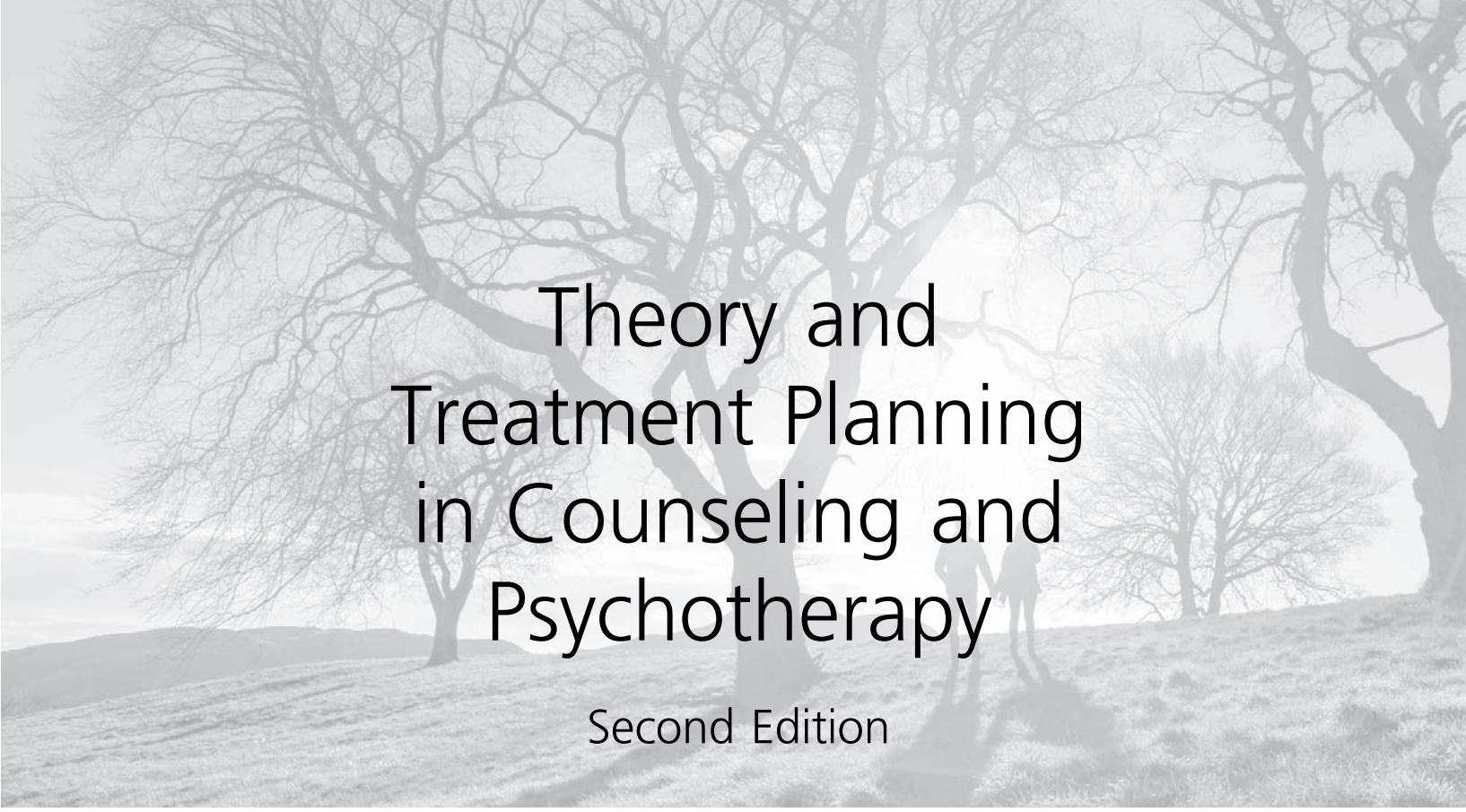

Theory and Treatment Planning in Counseling and Psychotherapy

Second Edition

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California State University, Northridge

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WCN: 02-200-202

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Library of Congress Control Number: 2015931696

ISBN: 978-1-305-08961-7

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Printed in the United States of America
Print Number: 01 Print Year: 2015

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Preface

Purpose of This Book

The second edition of *Theory and Treatment Planning in Counseling and Psychotherapy* is designed to be an efficient and highly effective means of introducing contemporary counseling theories. The text enables readers to skillfully apply theory in real-world settings by introducing theory-specific approaches to case conceptualization and treatment planning. Furthermore, readers learn about the evidence base for each theory as well as unique applications for specific culturally and sexually diverse populations. Unlike a typical textbook, this book is also intended to be used as a clinical reference manual to assist mental health professionals in their practice settings for years to come as a helpful aid for conceptualizing treatment with a wide range of clients, writing treatment plans, and preparing for licensing exams.

Overview of the Text

Using state-of-the-art pedagogical methods, the second edition of *Theory and Treatment Planning in Counseling and Psychotherapy* is part of a new-generation textbook specifically designed to thoughtfully promote student mastery of the material while enabling faculty to easily measure student learning outcomes, a task now required by all regional and professional accrediting bodies. Using a learning- centered, outcome-based pedagogy, the text engages students in an active learning process rather than deliver content in a traditional narrative style. More specifically, the text introduces counseling and psychotherapy theories using two clinically relevant assignments: a) theory-informed case conceptualization and b) theory-specific treatment planning. These assignments empower students to apply theoretical concepts and develop real-world skills as early as possible in their training, resulting in greater and quicker mastery of the material. Furthermore, the author uses a friendly and fun style to explain concepts in clear and practical language that contemporary students appreciate. Instructors will enjoy the simplicity of having the text and assignments work together seamlessly, thus requiring less time in class preparation and grading. The extensive set of instructor materials—which include syllabi templates, detailed PowerPoints, test banks, online lectures, and scoring rubrics designed for accreditation assessment—further reduce educators' workloads. In summary, the book employs the most efficient and effective pedagogical methods available to teach counseling and psychotherapy theories, resulting in a win-win for instructors and students alike.

What's New in the Second Edition

Instructors and students familiar with the first edition will notice a similar style and format and will also appreciate numerous enhancements:

- *Significantly Expanded and More Practical Diversity Sections:* The diversity sections in each theory chapter have been significantly expanded to include practical

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applications of the theory with specific diverse populations. Each chapter contains a discussion of both a) ethnic/racial diversity as well as b) sexual identity diversity. Expanded sections on specific populations provide students with detailed suggestions, adaptations, and cautions for using a given theory with a specific population, including African Americans, Hispanic/Latinos, Asian Americans, Native Americans/First Nation/Aboriginals, gay men, lesbians, and gay and transgendered youth.

- *New Chapter on Trauma-Related Evidence-Based Treatments:* The second edition includes a new chapter on evidence-based cognitive-behavioral treatments: dialectic behavioral therapy (DBT) and trauma-focused CBT for children. Both approaches are used extensively with clients who have experienced childhood and complex trauma.
- *Theory-Specific Case Conceptualization Templates:* Each theory chapter now includes a theory-specific case conceptualization outline that students and therapists can use to develop case conceptualizations using a single theory. This conceptualization can be used to create a theory-specific treatment plan. Each chapter has a sample theory-specific case conceptualization as part of the case study.
- *Revised Case Conceptualization and Treatment Plan Forms:* The cross-theoretical case conceptualization and treatment plan forms have been revised to be more succinct and easier to use. Digital forms are available for free download.
- *Jungian Chapter:* Jungian analysis is now covered in a separate chapter with a case study.
- *Practice Exercises:* Throughout the text, "try it yourself" exercises are provided to allow the reader to practice using assessment and intervention techniques.
- *Questions for Reflection and Class Discussion:* This is a new section added to each chapter to promote personal reflection and class discussion and to engage material more thoughtfully.

Appropriate Courses

A versatile book that serves as a reference across the curriculum, this text is specifically designed for use as a primary or secondary textbook in the following courses:

- Introductory or advanced counseling and psychotherapy theories courses
- Pre-practicum skills classes
- Practicum or fieldwork classes

Assessing Student Learning and Competence

The learning assignments in the text are designed to simplify the process of measuring student learning for regional and national accreditation. The case conceptualization and treatment plans in the book come with scoring rubrics, which are available on the student and instructor websites for the book at www.cengage.com; select materials are also available on www.masteringcompetencies.com. Scoring rubrics are available for all major mental health disciplines using the following sets of competencies:

- Counseling: Council on the Accreditation of Counseling and Related Educational Programs (CACREP) standards for each of the six areas of specialization
- Marriage and Family Therapy: MFT core competencies
- Psychology: Psychology competency benchmarks
- Social work: Council for Social Work Education (CSWE) accreditation standards

Each scoring rubric is linked to competencies identified in these disciplinary standards, and discipline-specific sample syllabi on the website include lists of the competencies covered on the treatment plan and case conceptualization assignments.

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Organization

This book is organized into three parts:

- *Part I: Introduction to Counseling Theories and Treatment Planning* provides an introduction to counseling, competencies, research, and treatment planning.
- *Part II: Counseling Theories* covers the major schools of counseling and psychotherapy theory.
  - Analytic Theories
    - Psychoanalytic and Psychodynamic Theories
    - Jungian Analysis
    - Adler's Individual Psychology
  - Humanistic-Existential Theories
    - Person-Centered
    - Existential
    - Gestalt
  - Action-Oriented Theories
    - Behavioral and Cognitive-Behavioral
    - Dialectic Behavioral Therapy
    - Trauma-Focused CBT
    - Family Systems
  - Postmodern Theories
    - Solution-Focused
    - Narrative
    - Collaborative
    - Feminist
- *Part III: Integration and Case Conceptualization* describes current trends toward integration and includes a comprehensive integrative case conceptualization approach to help solidify student understanding of theories.

The theory chapters in Part II are organized in a user-friendly way to maximize students' ability to use the book when developing case conceptualizations, writing treatment plans, and designing interventions with clients. The theory chapters follow this outline consistently throughout the book:

- *In a Nutshell:* The Least You Need to Know
- *The Juice:* Significant Contributions to the Field: If there is one thing to remember from this chapter it should be…
- *Rumor Has It:* The People and Their Stories
- *Big Picture:* Overview of Counseling Process
- *Making Connection:* Counseling Relationship
- *The Viewing:* Case Conceptualization
- *Targeting Change:* Goal Setting
- *The Doing:* Interventions
- *Case Conceptualization and Treatment Plan Templates*
- *Tapestry Weaving:* Working with Diverse Clients
  - Cultural Diversity
  - Sexual Identity Diversity
- *Try It Yourself:* Exercises to practice skills in the text
- *Questions for Personal Reflection and Class Discussion*
- *Case Example:* Vignette with
  - Theory-specific Case Conceptualization
  - Theory-specific Treatment Plan
- Online Resources
- References

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Accompanying This Text

Online Instructor's Manual The instructor's manual contains a variety of resources to aid instructors in preparing and presenting text material in a manner that meets their personal preferences and course needs. It includes sample syllabi, assignment templates, and scoring rubrics correlated with national accreditation bodies.

Online Test Bank For assessment support, the test bank includes multiple-choice questions for each chapter with references to the text.

Online PowerPoint® Slides These vibrant lecture slides for each chapter assist you with your lecture by providing concept coverage using content directly from your textbook.

CourseMate Available with the text, Cengage Learning's CourseMate brings course concepts to life with interactive learning, study, and exam preparation tools that support the printed textbook. CourseMate includes an integrated eBook, glossaries, flashcards, quizzes, videos, downloadable forms, assignment templates, scoring rubrics, and more. CourseMate also includes Engagement Tracker—a first-of-its-kind tool that monitors student engagement in the course.

Helping Professions Learning Center Designed to help you bridge the gap between coursework and practice, the Helping Professions Learning Center offers a centralized online resource that allows you to build your skills and gain even more confidence and familiarity with the principles that govern the life of the helping professional. The interactive site includes video activities organized by curriculum area accompanied by critical thinking questions; case studies built around ethics, diversity, and theory; flashcards and practice quizzes; a professional development center; and a research and writing center.

Select resources are also available at www.masteringcompetencies.com.

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Acknowledgements

I would like to thank the following content experts who gave their time and energy to ensure that the information in this textbook was accurate and current:

Rie Rogers Mitchell: Jungian sand play, psychodynamic theories
Luis Rubalcava: psychodynamic theories
Stan Charnofsky: humanistic, person-centered, Gestalt, existential
Wendel Ray and his doctoral students, Todd Gunter and Allison Lux: systemic theories
Marion Lindblad-Goldberg: systemic theories
Scott Woolley: emotionally focused therapy
Bill O'Hanlon: solution-based therapies
Harlene Anderson: collaborative therapy
Gerald Monk: narrative therapy
Ron Chenail: Competencies Assessment System
Thorana Nelson: Competencies Assessment System
William Northey: Competencies Assessment System
Jeremy Dastic: Case studies for Jungian and DBT chapters

Instructor and student materials second edition:

Diana Pantaleo
Rena Jacobs
Kayla Caceres

I would also like to thank the following people for their assistance on the second edition:

Kayla Caceres: Research assistant for the second edition
Eric Garcia: Librarian extraordinaire
Julie Martinez, Product Manager: My amazing and inspiring editor
Lori Bradshaw (from S4Carlisle), Content Developer: Editorial guidance and overseeing development of the instructor materials
Jean Smith: Permissions assistance
Anna and Guenther Gehart: For the extra hours taking care of Michael and Alex
Joseph McNicholas: For watching kids when I needed to write and for being my best friend
Michael McNicholas: For making each day a new adventure, for the best hugs ever, and for decorating my office with your art
Alexander McNicholas: For melting my heart each day with your "crazy cute" baby ways

Finally, I would like to thank the following reviewers and survey respondents who provided invaluable feedback on making this book work for faculty:

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Samantha Anders, University of Minnesota
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Nancy Baily, University of West Alabama
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About the Author

Photo by Jones Photo Art

DR. DIANE R. GEHART is a professor in the Marriage and Family Therapy and Counseling Programs at California State University, Northridge. Having practiced, taught, and supervised for over 20 years, she has authored/edited the following:

- *Mastering Competencies in Family Therapy*
- *Theory and Treatment Planning in Family Therapy*
- *Case Documentation in Counseling and Psychotherapy* (forthcoming)
- *Mindfulness and Acceptance in Couple and Family Therapy*
- *Collaborative Therapy: Relationships and Conversations That Make a Difference* (coedited with Harlene Anderson)
- *The Complete MFT Core Competency Assessment System*
- *The Complete Counseling Assessment System*
- *Theory-Based Treatment Planning for Marriage and Family Therapists* (coauthored)

She has also written on postmodern therapies, mindfulness, mental health recovery, sexual abuse treatment, gender issues, children and adolescents, client advocacy, qualitative research, and counselor and marriage and family therapy education. She speaks internationally, having given workshops to professional and general audiences in the United States, Canada, Europe, and Mexico. Her work has been featured in newspapers, radio shows, and television worldwide, including the BBC, National Public Radio, Oprah Winfrey's O magazine, and Ladies' Home Journal. She is an associate faculty member at three international postgraduate training institutes: the Houston Galveston Institute, the Taos Institute, and the Marburg Institute for Collaborative Studies in Germany. Additionally, she is an active leader in state and national professional organizations. She maintains a private practice in Agoura Hills, California, specializing in couples, families, women's issues, trauma, life transitions, and difficult-to-treat cases. For fun, she enjoys spending time with her family, hiking, swimming, yoga, meditating, and savoring all forms of dark chocolate. You can learn more about her work at www.dianegehart.com.

Author's Introduction

Bridge Across the Grand Canyon

Known for making its visitors audibly gasp in awe, the Grand Canyon is so wide at points that it is hard to see the other side. Having inspired reverence for generations, this great natural wonder provides many with a palpable experience of the divine. However, these qualities are not what I believe students over the years were referring to when they told me that the gap between their university coursework and fieldwork experiences was like the Grand Canyon. In marked contrast, my students were referring to the canyon's gaping and seemingly impassable chasms that appear impossible to traverse, at least not without hiring a personal jet, helicopter, or the starship Enterprise. Clearly, my students were feeling as though they were not able to connect their classroom experiences to their internships with the tools they had been given. Thus, I wrote this book to create a bridge across the Grand Canyon of Counseling—or at least a zip line—to help new counselors and therapists gracefully traverse two worlds that have been far too distant for too long: the worlds of academic theory and real-world practice.

You might be thinking, "That is a bold claim. How is she going to achieve this lofty goal?" As often happens in life, the answer lies in the question. In this case, the key is the term *goal*. As you learn about counseling and psychotherapy theories in this book, you are also going to learn how these theories are used to generate meaningful clinical goals to help clients and their counselors skillfully address the concerns brought to counseling. Thus, you will be introduced to counseling theories from the perspective of a practitioner more so than an academic. You will get less history and more information about how these ideas inform action in the counseling room. Furthermore, you will be given two vehicles for translating theory into practice: case conceptualizations and treatment plans. These tools are what counselors in the field use to help them do their job—and the versions in this book are specifically designed to integrate theoretical knowledge.

Enjoy the adventure!

Diane R. Gehart, Ph.D., Westlake Village, California

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Introduction

Start Here: Introduction and Instructions for Using This Book

Similar to most people reading this book, I was one of those students in school who always worked hard and went the extra mile. Perhaps I was simply a nerd (ironically, the last four digits of my family's childhood phone number was 4335, or G-E-E-K). Perhaps it was my immigrant father's constant reminder that without a good education one becomes a "ditch digger" or worse. Regardless of the reasons, I have always loved the whole school experience far more than playing soccer or watching television (confession: being bad at sports may have also played a role). This love of education may have started with those kindergarten activity books. Few things are more exciting than filling out these workbooks—pictures, colors, dots, lines, puzzles, and mazes—much more engaging than dull, dry, black-and-white textbooks (present text excluded, I hope).

In graduate school, this overdo-it tendency took another form: never leaving the library. When it came time to write the doctoral dissertation, which some consider the crowning academic assignment in Western civilization, it only seemed natural that one had to write an exhaustive literature review. It took me two years to write that review. Toward the end, my professor offhandedly mentioned that the review did not have to include every last study related to my topic. After a wave of now-you-tell-me thoughts washed over me, I returned to my personal brand of in-"sanity" (i.e., overdo-it logic) and said, "But I want to," and just kept searching for everything ever written on the subject (please note: my dissertation was written at a time in history when this was possible—the library had a "card catalogue" and only the earliest forms of digital databases).

Given this extreme tendency, it is astounding to look back and realize—and now confess to you—that I never once read the introduction to any of the hundreds of books I "read" in graduate school. Professors never listed them as required reading, the publisher never cared enough to give a formal chapter or real page number, and they were short, seemingly too short to possibly be of value. Now, sitting here writing to you, I realize that it was foolhardy to skip the introduction. In most cases, authors reveal the most important information, summarize the really big idea behind the book, and tell you how to read and learn from it. In short: it's where the most important information is (I guess that's why it goes first).

Thus, although anyone reading this book is likely to lean toward the industrious end of the spectrum (but not necessarily a geek and failed athlete like me), I am concerned that they may miss reading the information in the introduction, as I had for decades. So, to avoid that error—easily made by even the most devout learners—the introduction has been labeled "start here" in hopes you read those quick-start guides for your electrical gadgets. I hope that you will find that it greatly enhances your ability to get the most out of this book. Also, you may want to take a glace at introductions for your future reads.

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How This Book Is Different and What It Means to You

Theory and Treatment Planning in Counseling and Psychotherapy is a different kind of textbook. Based on a new pedagogical model, learning-centered teaching (Killen, 2004; Weimer, 2002), this book is designed to help you actively learn the content rather than my simply delivering the content and hoping that you'll memorize it. Thus, learning activities are woven into the text so that you have opportunities to apply and use the information in ways that facilitate learning (not unlike my son's elementary school activity books). The specific learning activities in this book are (a) case conceptualization and (b) treatment plans that translate the theory learned in each chapter to client situations. This book teaches real-world skills that you can immediately use to serve your clients better.

Also, this book is different in another way: it is organized by key concepts rather than general headings with long narratives sections. This organization—which evolved from my personal study notes for my graduate school and licensing exams back—facilitates the retention of vocabulary and terms because of the visual layout. Each year, I receive numerous emails from enthusiastic, newly licensed counselors and therapists thanking me for helping them pass their licensing exams—they all say that the organization of the book made the difference. So, spending some time with this text should better prepare you for the big exams in your future (and if you have already passed these, you should be all the more impressed with yourself for doing it the hard way).

Lay of the Land

This book is organized into three parts:

Part I: Introduction to Counseling Theories and Treatment Planning provides an introduction to counseling, competencies, research, and treatment planning.

Part II: Counseling Theories covers the major schools of counseling and psychotherapy theory.

- Analytic theories
- Humanistic-existential theories
- Action-oriented theories
- Postmodern theories

Part III: Integration and Case Conceptualization describes current trends toward integration and includes a comprehensive integrative case conceptualization approach to help solidify your understanding of theories.

Anatomy of a Theory

The theory chapters in Part II are organized in a user-friendly way to maximize your ability to use this book to support you when developing case conceptualizations, writing treatment plans, and designing interventions with clients. The anatomy of each of the theory chapters in Part II (Chapters 3–14) follows this outline:

Anatomy of a Theory

In a Nutshell: The Least You Need to Know
The Juice: Significant Contributions to the Field
Rumor Has It: The People and Their Stories
Big Picture: Overview of Counseling Process
Making Connection: Counseling Relationship

(*continued*)

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The Viewing: Case Conceptualization
Targeting Change: Goal Setting
The Doing: Interventions
Putting It All Together: Case Conceptualization and Treatment Plan Template
Snapshot: Research and the Evidence Base
Snapshot: Working with Diverse Populations
Online Resources
References
Case Example: Vignette with Case Conceptualization and Treatment Plan

In a Nutshell: The Least You Need to Know

The chapters begin with a brief summary of the key features of the theory. Although it may not be the absolute least you need to know to get an A in a theory class or help a client, it is the basic information you should have memorized and be able to quickly articulate at any moment to help you keep your theories straight.

The Juice: Significant Contributions to the Field

In the next section, I use the principle of primacy (first information introduced) to help you remember one of the most significant contributions of the theory to the field of counseling. In most cases, well-trained clinicians who generally use another approach to counseling are likely to be skilled and use this particular concept because it has shaped standard practice in the field. This section is your red flag to remember a seminal concept or practice for the theory. Feedback from students indicates this is often one of their favorite sections.

Rumor Has It: The People and Their Stories

In this section, you can read about the developers of the theory and how their personal stories shaped the evolution of the ideas. And, yes, some of the rumors are juicier than others. Since the focus of this text is how counseling theories are actually used in contemporary settings, I have deemphasized the history and development of the theory, but you will find brief summaries of such history here.

Big Picture: Overview of Counseling Process

The big picture provides an overview of the flow of the counseling process: what happens in the beginning, middle, and end, and how change is facilitated across these phases.

Making Connection: Counseling Relationship

All approaches start by establishing a working relationship with clients, but each approach does it differently. In this section, you will read about the unique ways that counselors of various schools build relationships that provide the foundation for change.

The Viewing: Case Conceptualization

The case conceptualization section will identify the signature theory concepts that counselors from each approach use to identify and assess clients and their problems. This really is the heart of the theory and where the real differences emerge. I encourage you to pay particularly close attention to these. You can also read more about case conceptualization in Chapters 15 and 16.

Targeting Change: Goal Setting

Based on the areas assessed in the case conceptualization and the overall counseling process, each approach has a unique strategy for identifying client goals that become the foundation for the treatment plan.

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The Doing: Interventions

Probably the most exciting part for most new counselors, this section outlines the common techniques and interventions for each theory. In some cases, a section for techniques used with special populations is included, if these are notably different from those in standard practice.

Putting It All Together: Case Conceptualization and Treatment Plan Template

After graduation, you will probably thank me most for this section, which provides a template for a treatment plan that can be used for addressing depression, anxiety, and similar concerns. This plan ties everything in the chapter together.

Tapestry Weaving: Working with Diverse Populations

This section provides a review of using the approach with a) ethnic and racial diversity and b) sexual identity diversity. In addition, unique applications for specific populations are also covered.

Research and the Evidence Base

This section reviews the research and evidence base for each theory, and this review is provided to offer a general sense of empirical foundations for the theory. In some cases, influential evidence-based treatments (see Chapter 1 for a definition) are highlighted.

Online Resources

A list of Web pages and Web documents are included for those who want to pursue specialized training or conduct further research on the theory.

References

Many students pass right over reference lists and forget all about them. But if you need to do an academic paper or literature review on any of these theories, the references should be your first stop. You might remember my historical difficulty with leaving the library. In this case, I had several hundred books go through my 12-by-12-foot office while writing this book over a two-year period, in addition to having PsychInfo set as my home page for faster lit searches (I discovered the joy of library eBooks). Thus, you can shorten the time it takes to locate key resources by pursuing these before you hit the library yourself (oh, I forgot, no one steps foot in these places any more; I meant "surf" the library's Web page while still in your bunny slippers—one of the joys of modern technology).

Case Example with Case Conceptualization and Treatment Plan

Finally, each chapter ends with a case vignette, case conceptualization, and treatment plan to give you a sense of how the theory looks in action and how to put it down on paper. I use examples of adults presenting for individual counseling in this text; see my other text *Mastering Competencies in Family Therapy* (Gehart, 2010) for examples with couples, families, and children. Again, I think you will find this most useful once your instructor or supervisor asks you to write one yourself.

Theoretical Friends and Families

Although each theory presented is wholly unique and independent, like the rest of us, each has friends and families with whom they associate. These are generally referred to as "schools" of counseling or therapy, and these are increasingly important as more and more counselors move toward integrated approaches (see Chapters 15 and 16). Unfortunately, like virtually all systems of grouping individuals, these groupings do not capture the full complexity of their characters. For example, in this book, Adlerian individual psychology is in the "analytic approach" section because it includes analytic elements;

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however, it also has humanistic, cognitive-behavioral, and even systemic elements. Obviously, reprinting the chapter four times would not help you, so you will have to read each chapter to learn about the similarities and differences between approaches in the same school. The rough and imperfect classifications of theories in this book are as follows:

Analytic approaches

- Psychodynamic
- Jungian analytic
- Adlerian individual psychology

Humanistic-existential approaches

- Person-centered
- Existential
- Gestalt

Action-based approaches

- Behavioral
- Cognitive-behavioral
- Systemic/family

Postmodern and multicultural approaches

- Solution-based
- Narrative
- Collaborative
- Feminist
- Reflecting teams

Voice and Tone

Finally, I should mention that the voice and tone of this textbook is a bit different from your average college read. I hope you have noticed by now that I am talking "right at ya." I also like to add some humor and have some fun while I write. Why? Well, first, I have more fun writing this way. But, more important, I want to engage you as if you were one of my students or supervisees learning how to apply these ideas for the first time. Counseling and psychotherapy are relationship-based practices, where both parties are fully present in their humanity (at least in most approaches). Thus, it is hard for me to write about how to be genuine and present to clients as a detached, faceless author. So, as I write, I am imagining you as a full and real person eager to learn about how to use these ideas to help others. I am going to try to reach out to you, answer questions I imagine you have, and periodically tap you on the shoulder to make sure you are still awake.

Suggested Uses

Suggestions for Thinking About Counseling Theories

As you read the chapters in this book, you are going to be tempted to identify which ones you like the best and deemphasize the ones you're less attracted to. This may seem like a great idea at first, but here are some points to consider:

Favorite versus Useful: The theories that the average counselor finds personally useful are probably not the same ones that the average client of new counselors is likely to find useful. Many counselors are psychologically minded, meaning that they enjoy thinking about the inner world and how it works. However, most new counselors begin

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working with diverse, multi-problem clients and families, many (but not all) of whom are not psychologically minded because they are often struggling with issues of survival and/or they come from cultural traditions that place less value on analysis and understanding of the inner world. So the theory you find most useful to you personally may not be a good fit for your first client.

Appreciation: The theories in this book are not casually chosen. They have become part of the standard canon of theories because generations of counselors and therapists have found them helpful. Each has wisdom worthy of study. The one lesson I have learned over the years is that the more theories counselors understand, the better able they are to serve their clients because their understanding of the human condition and its concomitant problems is broader. Thus, I recommend approaching each theory with an attitude of searching for its essential and useful parts. I facilitate this for you in the "Juice" section of each chapter that identifies the one thing you should work hardest to remember from the chapter.

Common Threads: Counseling theories are ironic: in one sense, they are very different and inform distinct and mutually exclusive behaviors and attitudes. However, the better you understand one, the better you understand them all. In fact, some counselors, the common factors proponents, argue that theories are generally equally effective because they are simply different modes for delivering the same factors (Miller, Duncan, & Hubble, 1997; you will read more in Chapter 1). So, it is quite possible that commonalities across theories are more important than their differences.

Suggestions for Using This Book to Learn Theories

First, I recommend that you set aside an hour or two to read about a single theory from beginning to end (from "In a Nutshell" to "Putting It All Together") to help get the full sense of the theory. Some chapters have a couple of theories in one, so for these it is fine to read the chapter in chunks. Additionally, some learners may find it helpful to scan the treatment plan (either the template or the example at the end of the chapter) or some other section first, to provide a practical overview; that said, I have tried to organize the ideas in the way most people seem to prefer. But I encourage you to discover what works best for you, since different learners have different strategies that work best for them. When you are done with a chapter, you might want to try completing a case conceptualization and treatment plan for yourself (you may have to make up a problem if you are nearly perfect) or for someone else, to get a sense of how this would work.

Finally, I strongly recommend that either after reading the chapter or after going to class, you take good old-fashioned notes. Yes, I mean it. I recommend that you type up (or, if you prefer, handwrite) a complete outline of the key concepts in your own words. Why do I advocate for such painful torture? All of us, myself included, when we read long, dense books such as this one, fade in and out of alert attentiveness to what we are reading—often lapsing into more interesting fantasies or less interesting to-do lists—and—gasp!—sometimes even skim large sections of the text (no, I am not surprised or offended). The only way to make sure that you really understand the concepts you read about is to put them in your own words and organize them in a way that makes sense to you. If you need to take culminating exams or plan to pursue licensure, you will have to log the concepts in this book into your long-term memory, which requires more than cramming for a final exam. Being a mental health professional requires that you master and build on what you learn, and you will be expected to know what is in this book for the entire time you are active in the profession (seriously—and if you think that is bad, just wait until you get to a class on diagnosis—you'll have to memorize an even longer book). Thus, if your former study habits included all-night cramming, gallons of espresso (or other favorite caffeine delivery system), and little recall after the exam, you might want to try my note-taking tip or some other strategy as you move forward.

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Suggestions for Using This Book to Write Treatment Plans

Because I know some of you might be tempted to skip ahead to the examples and avoid the boring theory, I feel it necessary to recommend taking a few minutes to read Chapter 2 on treatment planning before trying to quickly write one for class or your supervisor. There are some basic "rules" of good treatment planning that all counselors use and that are clearly spelled out in Chapter 2, and in the end, if you need to get a signature or grade on your treatment plan, it will save you lots of time to read the "how-tos" in Chapter 2 first.

I want to emphasize that the treatment plan format, templates, and examples in this book are just that: formats, templates, and examples. They do not represent the only approach or the only right approach but simply a solid approach based on the common standards and expectations. You most likely will work at a counseling agency or institution that uses another format, but the same general rules (the ones in Chapter 2) will still apply. That is why understanding the principles of how to write good goals and interventions is more important than memorizing the format.

Furthermore, don't use the templates and examples too rigidly. Feel free to modify the goal statements and techniques to fit the unique needs of your client. I have provided some relatively specific goals as an example of what might work, and I encourage you to tailor these for each client's unique needs.

Suggestions for Use in Internships and Clinical Practice

When working as an intern or licensed mental health professional, this book can be useful for teaching yourself theories and techniques in addition to learning how to write treatment plans. You will likely find that when you work with new populations and problems, you may be interested in considering how other therapy models might approach these situations. This book is designed to be a prime resource for quickly scanning to identify other possibilities. Alternatively, you might have a colleague or supervisor who uses a theory with which you are not familiar. You can use this book to quickly review that theory and avoid looking uneducated. In addition, this book is written to help you appreciate and find common ground across theories, which can be of particular benefit when working in a "mixed-theory" context. However, to actually learn to practice any of these theories well, I strongly urge you to take advanced training from experts in that approach.

Suggestions for Studying for Licensing Exams

Licensing exams are designed not to be unnecessarily tricky or scary but simply to ensure that you have knowledge necessary to practice counseling and psychotherapy without supervision and to not harm anybody. And it is a vocabulary test. If you have honestly engaged your classes, done your homework, avoided cramming for tests and papers, and made it a priority to get decent supervision, you should have a strong foundation for taking your licensing exam. You should already have in your possession books (such as this) that cover all the content to be studied for the exam. If your exam is to be taken on finishing a lengthy post-master's internship, you should use the entire two- to four-year period to read as many books as possible on the theories and materials covered by the exam (no novels for a few years).

I do not recommend that all my students take long, expensive "review courses," because such courses are not necessary for those who are proactive in mastering the material on the exam long before they sign up to take it. If you start studying only after you are approved to take the test, you are starting about two to four years too late—and then, yes, you will need to take a crash course. My basic suggestion for studying for mental health licensing exams is this: read an original text on each major theory during your post-degree internship, use the Diagnostic and Statistical Manual of Mental Disorders (DSM), keep up with laws and ethics, then buy the practice exams (without the study guides) and take them until you consistently get 5% above the required passing score (e.g., 75% if the passing score is 70%). If you find that you are weak in a particular area, such as theory or DSM, use a text such as this, which is designed with the

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license review in mind. Once you consistently get 75%, you are ready to take the test with the most learning and the least expense.

Suggestions for Faculty to Measure Competencies and Student Learning

This book is designed specifically to help faculty and supervisors simplify and streamline the onerous task of measuring student competencies as required by the various accreditation bodies. The forms and scoring rubrics for assessing student learning using counseling, psychology, social work, and family therapy competencies are available on this book's Web page for instructors (see www.cengage.com or www.masteringcompetencies.com). On this website, instructors will also find free online lectures, PowerPoints, sample syllabi, and a test bank (test banks are available only from your Cengage sales representative, in order to maintain security of the questions). This text may be used as the primary or secondary text in a counseling theories class or as the primary text in a pre-practicum or practicum/fieldwork class. Because of its combination of solid theory and practical skills, it can easily be used across more than one class to develop students' abilities to conceptualize theory and write treatment plans, skills that are not likely to be mastered in a single class.

When designing a class to measure competencies and student learning using these treatment plans and case conceptualizations, I recommend initially going over the scoring rubrics with students so that they understand how these are used, to clearly define what needs to be done and the expectations for the final product. I have found that it is most helpful to provide two or three opportunities to practice case conceptualization and treatment planning over a semester, in order to provide feedback and enable students to improve and build on these skills in a systematic fashion. The online instructor resources include several example syllabi for the various mental health disciplines. Specifically, I have a small group present a case conceptualization and treatment plan with each theory studied, based on a video the class watches on the theory; that way, students have enough information to actually conceptualize the client dynamics and treatment. Then, the entire class can see an example and discuss the thought process of developing the plan. A later or final assignment for the class can be to independently develop a treatment plan for a case (either one assigned by the instructor or one from a popular movie, personal life, or actual client). By the end of a semester with these activities, students will have developed not only competence but also confidence in their case conceptualization and treatment planning abilities.

Student Resources

Students will find numerous useful resources for this text on the Cengage website (www.cengagebrain.com), with select resources on the text's website (www.masteringcompetencies.com). These include the following:

- Online lectures: mp4 recordings of yours truly discussing content of the various chapters
- Digital forms for the treatment plan and integrative case conceptualization
- Scoring rubrics
- Links to related websites and readings
- Glossary of key concepts and terms
- Web quizzes

Instructor Resources

Instructors will find numerous resources for the book online on the Cengage website (www.cengage.com) and select resources on the text's websites (www.masteringcompetencies.com):

- Online lectures by the author
- Sample syllabi for how to use this book in a theory class or practicum class in counseling, family therapy, psychology, or social work. These syllabi include detailed lists of the competencies covered for each discipline—to meet accreditation requirements.

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- Detailed PowerPoints for all of the chapters
- Downloadable versions of the integrative case conceptualization, treatment plan, and scoring rubrics (rubrics are correlated to competencies for each of the CACREP specialities as well as the core competencies/benchmarks for family therapy, psychology, and social work)
- Test bank and Web quizzes

Next Steps

Now that you are acquainted with the lay of the land, it is time to get down to business. In the chapters that follow, you will learn more about competencies in the field of counseling and psychotherapy and what they mean for you and your future as a professional. Part of this tour includes a review of what it means to be a professional and the ethical duties that come with the job. We will also explore the purpose of counseling theories and consider two streams of research that inform the use and development of these theories: the common factors research and evidence-based treatment studies. Then you will learn about the nuts and bolts of treatment planning in Chapter 2. This one may be a bit dry, but I promise that once you are assigned to write your first treatment plan, you will find it to be one of the most exciting in this book—nothing like the pressure of having to write your first plan to alter your perspective of what is fascinating. The remainder of this book will take you on a grand tour of some of the most exciting ideas from the 20th and 21st centuries. I have confidence that it will be the trip of a lifetime.

Bon voyage!

And congratulations on reading this book's introduction! I hope you can see the value now.

Online Resources

Webpage for this book: www.cengagebrain.com

With select resources also on www.masteringcompetencies.com

Student Resource Page:

- Treatment plan and case conceptualization forms
- Scoring rubrics
- Online lectures
- Glossary of key concepts and terms

Instructor Resource Page:

- Sample syllabi with detailed list of competencies covered in the class
- PowerPoints for each chapter
- Treatment plan and case conceptualization forms
- Scoring rubrics correlated to accreditation competencies for counseling, family therapy, psychology, and social work
- Test bank and Web quizzes

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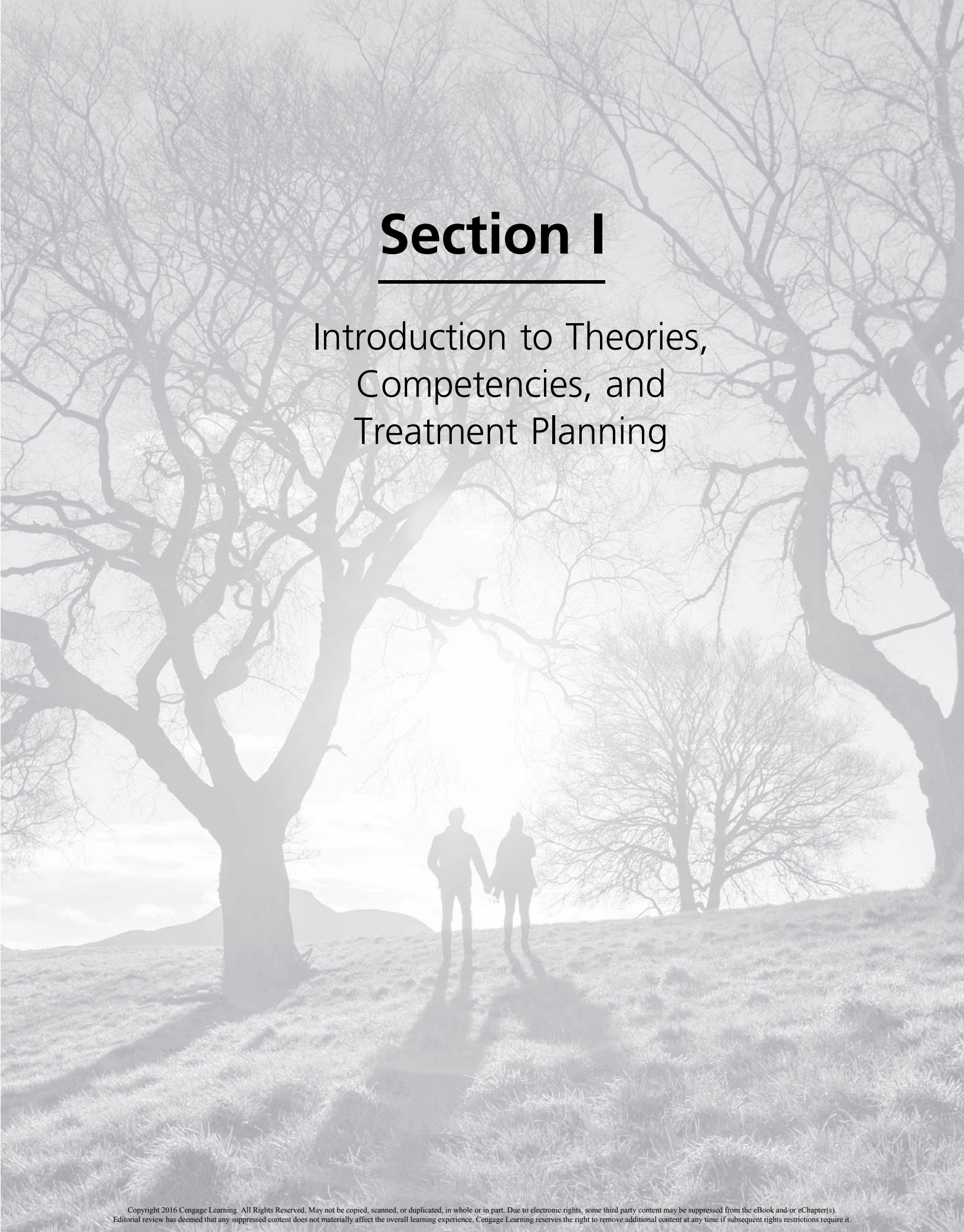

Section I

Introduction to Theories, Competencies, and Treatment Planning

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CHAPTER

1

Counseling Theory, Competency, Research, and You: Connecting the Dots

What Distinguishes a Counselor from a Bartender?

What makes a counselor or therapist different from a good bartender, hairdresser, or friend? In many cases, the latter are excellent listeners, can be empathetic, and help solve problems. Aside from the obvious fact that bartenders and friends typically charge less for their services—not always true for hairdressers—counselors go beyond these basic helping skills and do something more. Counselors use *theory* to (a) develop a specific form of helping relationship, (b) articulate more useful understandings of clients' situations, and (c) identify effective means to resolve clients' presenting problems. In the end, it is the ability to skillfully translate theory into action that makes counselors different from those helpful others. Counseling theories provide powerful lenses through which to view clients' situations and identify the most expedient means to resolve their concerns. This book will show you how counselors do it—and perhaps one day you will use this skill set to justify your fee, which might rival that of one of the better stylists in town.

Why Theory Matters

Although much has changed over recent decades in mental health care—better research to guide us, new knowledge about the brain, more details about mental health disorders, and increased use of psychotropic medication—the primary tool that counselors and psychotherapists use to help people has not: *theory*. Counseling theory provides a means for quickly sifting through the tremendous amount of information clients bring; then, targeting specific thoughts, behaviors, or emotional processes for change; and finally, helping clients to effectively make these changes to resolve their initial concerns. Even with fancy functional magnetic resonance imaging, neurofeedback machines, and hundreds of available medications, no other technology has taken the place of theory. However, the changing landscape of mental health care has changed how counseling theories are understood and used.

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Connecting with Theory: Do I Have to Choose Just One?

Over the years, the role of theory in counseling and psychotherapy has become less rather than more clear. Initially, the general recommendation was to select and train in one theory, which became a counselor's primary identity and style of working; it was a personal choice, and the story ended there. Textbooks such as this one are grounded around this honorable tradition, a tradition in which I was "raised." However, many counselors like to "mix it up," integrating theories, which has been an increasingly popular and justified practice in the field (see the "Common Factors Research: Reframing Theory" section; Miller, Duncan, & Hubble, 2004).

Similarly, many of my students, on reading their first theory textbook, enthusiastically exclaim, "I like them all; do I have to choose?" It's one of those questions that they quickly regret asking. Because rather than give a simple yes-or-no answer (anyone who asks is hoping for "no"), I must instead go into a long lecture on epistemological foundations, developmental stages of becoming a counselor, research on outcomes, evidence-based treatment, and so on. Within 15 minutes, the class gets very quiet. After half an hour, most are scrunching their faces with stress. By the end of the first hour, all have given up hope for a simple answer to their question. So now it's your turn to listen to the answer to this question, and out of compassion, I will provide you with a quick overview and road map.

Counseling theory and how it is being used and understood has been recontextualized by two major movements in recent years: (a) the competency movement, which includes multicultural competency, and (b) the expanding research base and the evidence-based treatment movement. These movements have not ended the need for theory but have instead changed how we conceptualize, adapt, and apply theory. The remainder of this chapter will address these two major movements and discuss their relationship to competency, theory, and you.

- **Competency: Common Threads in Competent Use of Theory**
  - Diversity and multicultural competence
  - Research competence
  - Law and ethics
  - Person-of-the-counselor
- **Research and the Evidence Base: Reframing and Redesigning Theory**
  - Common factors (across theories) research
  - Evidence-based practice and treatments
  - Evidence-based practice principles

Competency in Counseling and Psychotherapy

Stereotypes are dangerous and typically inaccurate. Nonetheless, I am going to risk stating such a generalization, namely, that counselors and therapists care about others. Most counselors feel called to the profession to help others and to make a difference in the world. Few report being motivated by fame and riches, as there are easier and more expedient means to these ends (you may need to chat with a career counselor if this comes as a surprise). Many find inspiration from the work of Carl Rogers (1951, 1961), who radically claimed that accurate empathy, unconditional positive regard, and genuineness are not only necessary but also *sufficient* conditions for promoting change in clients. At the grassroots level, clients often describe effective counselors as "nice," good-hearted people. Research indicates that this human connection is one of the strongest predictors of change in the counseling process (Miller, Duncan, & Hubble, 1997). But the counseling relationship does not account for all the change; in fact, many argue that it is not enough.

Regardless of whether you side with Rogers or those who claim that more is needed, competent counseling in the 21st century demands that counselors do more than care, that they are more than nice, and that they demonstrate more than the core conditions that Rogers advocated. The standard of practice in today's treatment environments

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involves several key elements that counselors must master to be considered *competent*: having the necessary skills for the job. All mental health professionals who provide counseling and psychotherapy services—including counselors, family therapists, clinical and counseling psychologists, clinical social workers, psychiatric nurses, and psychiatrists—must master a core set of competencies. The core elements of competent counseling are consistent across disciplines, but the specifics of how they are enacted can vary by training and discipline.

Competency and (Not) You

Although at first it may seem insensitive, the vernacular expression commonly used by my teen clients sums up the mind-set of competency best: "It's not about you." It's not about *your* theoretical preference, what worked for *you* in your personal counseling, what *you* are good at, what *you* find interesting, or even what *you* believe will be most helpful. Competent counseling requires that *you* get outside your comfort zone, stretch, and learn how to interact with clients in a way that works for *them*. In short, you need to be competent in a wide range of theories and techniques to be helpful to all the clients with whom you work. If you allow me to go on, you might even begin to see how this makes some sense and might even be in your best interest.

Perhaps it is best to explain with an example: you will likely either have a natural propensity for generating a broad-view case conceptualization using counseling theories, or you will have a disposition that favors a detail-focused mental health assessment and diagnosis; humans tend to be good either with the big picture or with details. However, to be competent, a counselor needs to get good at doing both, even if one is easier, preferred, and philosophically favored. Similarly, you may prefer theories that promote insight and personal reflection; after all, that may be what works for *you* in *your* life. However, that may not work for your client, and/or research may indicate that such an approach is not the most effective approach for your client's situation or background. Thus, you will need to master theories of counseling that may not particularly interest you or even fit with your theory of counseling. Although at first you may not like this idea, I think that by the time you are done with this book, you might just warm up to it.

I first learned this competency lesson when working with families in which the parents had difficulty managing the behaviors of their young children. I was never a huge fan of behaviorism, but it did not take too many hysterically screaming, clawing, and biting two-year-olds before I was preaching the value of reinforcement schedules and consistency. Given my strong—admittedly zealous—attachment to my postmodern approach at the time, I have every faith that you will be driven either by principle (ideally) or by desperation (more likely) to move beyond your comfort zone to become a well-rounded, competent counselor.

Common Threads of Competency

Although each major mental health profession—such as counseling, marriage and family therapy, psychology, psychiatry, psychiatric nursing, and chemical dependency counseling—uses a different set of competencies, there are many similarities across them. They agree that competent use of theory entails attending four key areas:

- *Diversity and multicultural competence:* The use of counseling theory is always contextualized by diversity issues, which means that the application and applicability varies—sometimes dramatically—on the basis of diversity issues such as age, ethnicity, sexual orientation, ability, socioeconomic status, immigration status, and so on.
- *Research and the evidence base:* To be competent, counselors must be aware of the research and the evidence base related to their theory, client populations, and presenting problem.
- *Ethics:* Perhaps the most obvious commonality across sets of competencies is law and ethics; without a firm grasp of the laws and ethical standards that relate to professional mental health practice, well, let's just say you won't be practicing very long.

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A solid understanding of ethical principles such as confidentiality is a prerequisite for applying theory well.

- *Person-of-the-counselor/person-of-the-therapist:* Finally, unlike most other professions, specific personal qualities are identified as competencies for mental health professionals.

Diversity and Competency

Over the past couple of decades, counselors have begun to take seriously the role of diversity in the counseling process, including factors such as age, gender, ethnicity, race, socioeconomic status, immigration, sexual orientation, ability, language, and religion. These factors inform the selection of theory, development of the counseling relationship, assessment and diagnosis process, and choice of interventions (Monk, Winslade, & Sinclair, 2008). In short, everything you think, do, or say as a professional is contextualized and should be informed by diversity issues. If you think that effectively responding to diversity is easy or can be easily learned, or that perhaps your instructors, supervisors, or some famous author has magic answers to make it easy, you are going to be in for an unpleasant surprise. Rather than a black-and-white still life, dealing with diversity issues is more like finger painting: there are few lines to follow, it is messy for everyone involved, and it requires enthusiasm and openheartedness to make it fun.

I have often heard new and experienced counselors alike claim that because they are from a diverse or marginalized group, they don't need to worry about diversity issues. Conversely, I have heard counselors from majority groups say things such as "I don't have any culture." Both parties have much to learn on the diversity front. First of all, we are all part of numerous sociological groups that exert cultural norms on us, with the more common and powerful ones stemming from gender, ethnicity, socioeconomic class, religion, and age. Many, if not most, Americans belong to some groups that align more with dominant culture and with some that are marginalized. However, it is important to realize that some groups experience far more traumatic and painful forms of marginalization than others, and to further complicate matters, each individual responds to these pressures differently.

To illustrate, some people experienced the process of coming out as gay as highly traumatic and want counselors to address these issues gingerly, while others find it insulting when counselors *assume* that they feel oppressed due to sexual orientation because they live in communities that are largely supportive. Furthermore, many Americans seem unaware that there is a very strong and distinct "American culture" of which they are a part; in fact, the various regions of America have very unique characteristics of which counselors need to be aware. As another example, midwestern men typically express their emotions far differently than men in California, and counselors who expect the two types of men to handle emotions in a similar way are going to unfairly pathologize one or the other.

Suffice it to say that competently handling diversity issues requires great attention to the unique needs of each person, and it is a career-long struggle and journey that adds great depth and humanity to the person of the counselor. In this book, you will begin this journey by examining diversity issues related to each of the theories covered and will start integrating these issues into treatment planning. Toward the end of each chapter, diversity issues related to ethnicity, race, and sexual identity are discussed in as much detail as the existing literature base allows. You will find that detailed and practical discussions are included throughout the chapter as they relate to specific concepts and interventions for each theory. You will be challenged to think and apply diversity issues in each theory's treatment plan and in the cross-theoretical case conceptualization (Chapter 16).

Research and Competency

Another common thread found in mental health competencies is understanding and, more important, *using* research to inform treatment and to measure one's effectiveness and client progress. In recent years, there has been powerful movement within the field

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to become more evidence-based in mental health care, which involves two key practices: (a) using existing research to inform clinical decisions and treatment planning and (b) learning to use evidence-based treatments, which are specific and structured approaches for working with distinct populations and issues (Sprenkle, 2002). These movements are discussed in detail later in this chapter (perhaps in too much detail for some), and issues related to the evidence base for each counseling theory are also discussed at the end of each theory chapter, with related evidence-based treatment highlighted. If you were hoping to escape discussion of research in your theory text, you will be initially disappointed, but I hope that by the end you find the integration an invigorating addition.

Law, Ethics, and Competency

I often quip with students entering the field that if they think counselors can cut corners with legal or ethical issues, they should transfer to a business program so that they can make some money without worrying about such details and avoid a felony prison sentence after working as an unpaid intern for four or more years. Okay, that might be a bit of an exaggeration (there *is* a field called business ethics), but I hope the message is clear. Counselors who fail to develop competence in legal and ethical issues will not last long. Although this book does not directly cover these issues, they are so central to the profession that even before you begin reading about theories and treatment planning, you need a brief introduction, because you might just be tempted to run off and start applying the concepts in this book to identify the underlying causes of problems in your clients, friends, family, neighbors, pets, and self. All mental health professional organizations—such as the American Counseling Association, the American Association for Marriage and Family Therapy, the American Psychological Association, and the National Association of Social Workers—have codes of ethics that their members must follow. Thankfully, there is significant agreement between the various organizations, resulting in general agreement on most key issues; federal and state laws also generally agree on the key principles. Although ethical and legal issues require their own textbook to adequately address their nuances, I will quickly review some of the more applicable guidelines here:

- *Confidentiality:* Client information is confidential, meaning that it cannot be shared with others unless written releases or state law permit; *if you are using real clients for the exercises in this book, you must take steps to remove any and all identifying information before turning in your work.*
- *Diversity:* Counselors adapt assessment and treatment approaches to be respectful of and appropriately adapted for client diversity, including ethnicity, age, gender, socioeconomic status, physical and mental ability, sexual orientation, religious beliefs, language, and so on.
- *Scopes of competence and practice:* Counselors practice only within their *scope of competence*, areas in which they have been adequately trained, or they obtain supervision in areas of growth; if you are using this book in a class setting, your instructor will serve as your supervisor in how to use the concepts in this book. The *scope of practice* refers to what one's specific license allows one to do (e.g., licensed counselors are not allowed to do personal training under the license).
- *Dual relationships:* Counselors avoid dual relationships with clients to avoid exploitation, meaning that counselors should avoid working with people they know from other contexts (although this varies from country to country). Thus, I recommend that you avoid trying to casually assess, treat, or otherwise make sense of your family and friends by trying to apply the ideas in this book (as tempting as it is sometimes).
- *Defining the client:* When initiating counseling with individuals, couples, or families, the counselor carefully identifies "who" the client is (the individual, couple, or family system) and discusses how confidential information will be handled between clients.
- *Children's rights to confidentiality:* A particularly difficult issue when working with children and families are children's rights to privacy and confidentiality versus the

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parents' right to information about their children. Each state has different laws pertaining to children's rights to privacy, with more progressive states allowing children or teens with serious disorders to seek treatment without the knowledge of their parents (counselors need to justify potential harm) and more conservative states allowing parents full access to children's treatment information.

- *Personal concerns:* When counselors become aware of personal concerns that may affect their ability to interact, assess, or intervene with a client, the counselor addresses these issues by seeking personal psychotherapy, supervision, or otherwise resolving the problem. Most training programs (and many state legislatures) strongly encourage counselors in training to seek their own personal counseling.
- *Mandated reporting:* Most states have detailed laws that require counselors to report suspected child abuse and neglect, elder abuse and neglect, dependent adult abuse, serious suicidal threats, homicidal threats, and threats to personal property. Additionally, ethical standards encourage counselors to take action to manage self-harming behaviors and domestic violence that involve serious life-threatening issues not typically addressed by state laws.

Person-of-the-Counselor and Competency

Finally, being a competent counselor or therapist requires particular personal characteristics that are often difficult to define. Some qualities are basically assumed to be prerequisites for a professional—integrity, honesty, and diligence—and take the form of following through on instructions the first time asked, raising concerns before they spiral into problems, staying true to one's word, and so on. It is hard to establish competency in anything without these basic life skills.

The more subtle issues of the person-of-the-counselor come out in building relationships with clients. To begin with, the research is clear that clients need to feel heard, understood, and accepted by counselors, which often takes the form of offering empathy and avoiding advice giving (Miller et al., 1997). Furthermore, counselors need to identify and work through their personal issues to avoid bias or what psychodynamic counselors call *countertransference* (see Chapter 3 for a full discussion). Although more difficult to quantify, these issues often become quickly apparent by strong emotions or unusual interactions in relationships with clients, supervisors, instructors, and peers. Managing these well is part of being a competent counselor.

Finally, a more difficult aspect to define is *therapeutic presence*, a quality of self considered to have intrapersonal, interpersonal, and transpersonal elements, including elements of empathy, compassion, charisma, spirituality, transpersonal communication, patient responsiveness, optimism, and expectancies, making it elusive and difficult to operationalize (McDonough-Means, Kreitzer, & Bell, 2004). Clients—rather than a professional—are the best judges of this subtle quality because in the end it comes down to how the client experiences the counselor as a human being in the room. Although these competencies are more difficult to measure, they are nonetheless some of the more important to develop.

Research and the Evidence Base

Research and the evidence base have presented the greatest challenge to how counselors have traditionally thought about theory: as a personal choice that each counselor makes on the basis of personal beliefs about the human condition and the best remedies for suffering. Instead, two seemingly disparate streams of research have upset the proverbial applecart and forced counselors and therapists to reexamine their assumptions about theory: the common factors research and the evidence-based treatment research. The common factors research draws on studies that indicate that it is the common elements

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across theories that account for the effectiveness of counseling, thus undermining the often vicious competition between models of therapy to determine who is "king of the hill." From the other direction, evidence-based treatments focus on developing specifically designed treatments for particular populations to improve outcomes, thus promoting a paradigm of selecting theory on the basis of client needs rather than therapist preference. As you can imagine, these two streams of research have led to impassioned debates in the field, deliberations you are sure to be part of in the years ahead.

Common Factors Research: Reframing Theory

Much of the questioning of the role of theory has been spurred by what is commonly referred to as the *common factors debate* (Blow, Sprenkle, & Davis, 2007; Duncan et al., 1997; Sprenkle & Blow, 2004; Sprenkle, Davis, & Lebow, 2009). In a nutshell, the common factors proponents contend that the effectiveness of counseling has more to do with key elements found in all theories rather than the unique components of a specific theory. To simplify the argument even further, *it is the similarities more than the differences across models that are the critical change element*. This position is supported by meta-analyses (research on several research studies) of the outcome studies in the field: when confounding variables are controlled for (e.g., counselor loyalty, comparison group, measures of outcome), there is little evidence to support the superiority of one theory over another (Lambert, 1992; Wampold, 2001).

Within the common factors community, there are differences in the valuing of theoretical models. Some (Duncan et al., 1997) lean toward emphasizing the common factors while minimizing the role of theory, while others take a more moderate approach (Sprenkle & Blow, 2004), maintaining that theories are still important because they are the *vehicles through which* counselors deliver the common factors and that specific models may have an added benefit in certain contexts. Sprenkle and Blow (2004) emphasize that the common factors approach requires counselors not to relinquish counseling models but rather to understand their purpose differently. Rather than the "answer" or "truth" that solves the client problems, common factor proponents propose that using a structured treatment allows counselors to coherently actualize common factors, inspiring confidence from clients in the counseling process. From this perspective, a counseling model is better understood as *a tool that increases counselor effectiveness* rather than the "one and only true path" that resolves the client's problem.

The most frequently cited common factors model is grounded in the work of Michael Lambert (1992). After reviewing outcome studies in psychotherapy, he *estimated* that outcome variance (the degree to which change is attributed to a specific variable) could be attributed to the following factors:

Lambert's Common Factors Model

- *Client factors:* Approximately 40%. Includes client motivation, resources, and so on.
- *Therapeutic/Counseling relationship:* Approximately 30%. Quality of the counseling relationship as the *client* evaluates it.
- *Therapeutic/Counseling model:* Approximately 15%. Counselor's specific model and techniques used.
- *Hope/placebo effect:* Approximately 15%. Client's level of hope and belief that counseling will help.

Often these percentages are cited as "fact," and although they are well-informed estimates based on a careful analysis of existing research, the numbers were not generated through an actual research study. These should be considered general trends in the research that inspire counselors to critically reconsider how they can help clients, rather than exact percentages that should dictate how counselors operate.

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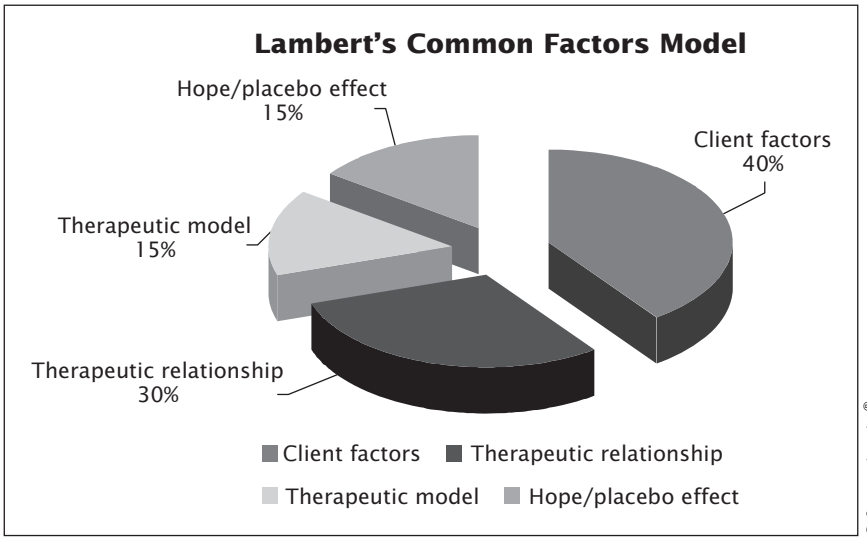

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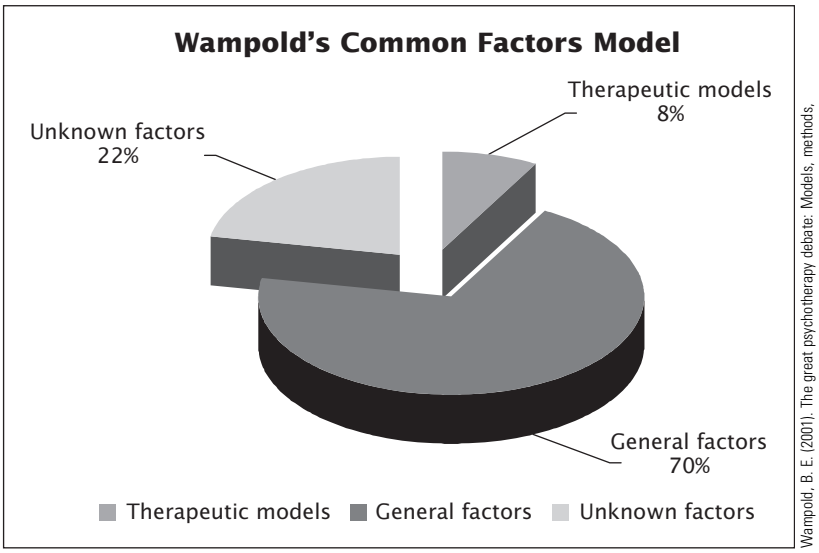
Wampold (2001), who conducted a meta-analysis similar to Lambert's but compared only studies that included two or more bona fide counseling models (rather than comparing a model to the generic "treatment as usual" or a no-treatment control group), presents evidence for the following:

Wampold's Common Factors Model

- *Therapeutic/Counseling models:* 8%. Unique contributions of specific theory (compare with 15% above).
- *General factors:* 70%. Counseling alliance, expectancy/hope, and so on.
- *Unknown factors:* 22%. Variance that is not related with known variables.



Wampold, B. E. (2001). The great psychotherapy debate: Models, methods, and findings. Mahwah, NJ: Erlbaum.

Wampold's research further underscores that common elements across theories may contribute to a positive counseling outcome more than the unique elements of a specific theory. Thus, research across theories continually points to general or common factors having the greatest impact on outcome; of course, this may be due to the limits of our

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research (Sprenkle & Blow, 2004) or other factors, but for now, this is the best information we have on the subject.

Client Factors

Lambert's (1992) research, which has been made most accessible to clinicians in the work of Miller et al. (1997), emphasizes the importance of activating client resources, such as encouraging clients to create and use support networks and increasing client motivation and engagement in the process. Tallman and Bohart (1999) propose that the reason most theories work equally well is due to the client's ability to adapt and utilize whatever techniques and insights the counselor may offer, the counseling process effectively becoming a Rorschach-like inkblot that the client uses to create change. Miller et al. (1997) describe two general categories of client factors—client characteristics and extratherapeutic factors:

- *Client characteristics:* Client motivation to change, attitude about counseling/change, commitment to change, personal strengths and resources (e.g., cognitive, emotional, social, financial, spiritual), duration of complaints, and so on.
- *Extratherapeutic factors:* Social support, community involvement, fortuitous life events, and so on.

Counseling Relationship

A consistent finding in both Lambert's and Wampold's research, the quality of the counseling relationship appears to be more important than the specific model in predicting outcome; this finding is consistent with much of the traditional wisdom in the field. An effective counseling relationship is characterized by accommodating to the client's level of motivation, working toward the client's goals, and demonstrating a genuine, nonjudgmental attitude. A particularly interesting—and humbling—finding, the *client's evaluation* of the relationship is more strongly correlated with positive outcome than is the counselor's evaluation (Miller et al., 1997).

Despite the clear and consistent evidence regarding the importance of the counseling relationship, the majority of outcome studies in the field, especially studies on evidence-based therapies, try to control for and factor out the impact of the counselor on treatment, thereby obscuring the role of the counselor in effective treatment (Blow et al., 2007). Perhaps because it is difficult to fully operationalize and measure the quality of the counseling relationship, or perhaps because researchers want a more scientific-sounding explanation (the treatment did it, not the relationship), the research literature seems to undervalue and underestimate the importance of the counseling relationship. The common factors research redirects counselors' attention to the importance of the counseling relationship.

Theory-Specific Factors: Techniques

Theory-specific factors refer to the "doing" of counseling: what the counselor says and does to facilitate change. This typically is what counselors and third-party payers think of contributing most directly to change. Lambert's (1992) research and estimations indicate that technique may not be *as important* as typically assumed, as it may account for only *half* the outcome variance in comparison with the counseling relationship. However, it is still an influential factor over which counselors have significant control. Thus, new counselors still need to study books such as this.

Hope and Expectancy

Hope, expectancy, or the *placebo* effect, which refers to the client's belief that counseling will be helpful to them in resolving their problem, is a specific client factor emphasized in Lambert's (1992) research. Lambert's emphasis of this factor heightens counselors'

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awareness of an often neglected aspect of the counseling process, at least in the research literature (Blow et al., 2007). Aware of the potential impact of hope, counselors can more consciously work to instill hope, which is particularly critical in the initial sessions.

Try It Yourself

Find a partner and discuss a situation in which you experienced hope. How did it affect your motivation and ability to resolve the problem?

Diversity and the Common Factors

Common factors can be particularly useful when working with diverse clients—whether culturally, sexually, linguistically, ability-wise, or otherwise—because diversity *always* implies unique client resources and challenges, particularly for the counseling relationship, choice of approach, and strategies for instilling hope. For example, when working with marginalized social groups such as gay/lesbian/bisexual/transgendered clients, although they are ostracized in the general community, many have extensive informal and formal social networks, creating a unique social support; the same is true of many ethnic groups and disabled or chronically ill people. Thus, the inherent societal challenge is partially offset with unique resources. Counselors can help clients leverage these resources to better manage the complementary and often daunting challenges of being different from the majority.

Similarly, creating an effective counseling relationship requires counselors to create a relationship where the client feels accepted rather than judged; with diverse clients, the task requires more mindfulness and thoughtfulness because there are often dynamics and traditions of which the counselor may not be aware. Education on local diverse communities is of course necessary, but humility and admitting that you do not know is often even more important because it cultivates respect and openness (Anderson, 1997). When counselors working with diverse clients proceed with curiosity and a willingness to learn, they often discover distinct and effective means for instilling hope in a way that is deeply meaningful from within the client's culture and primary community, further strengthening the counseling relationship.

Do We Still Need Theory?

The natural question that follows from the common factors debate, the one my students are quick to ask, is *do we still need theory?* As noted by Sprenkle and Blow (2004), some counselors lean toward the "dodo bird verdict," suggesting that theory matters very little. The more moderate stance of Sprenkle and Blow (2004) emphasizes that "the models are important because they are the vehicles through which the common factors do their work" (p. 126).

Following this moderate position, theory still plays a critical role for new and seasoned clinicians; the catch is that it is not the role one might initially expect it to play. It seems logical and reasonable to think that the role of theory is to provide a system to help clients alleviate their symptoms and resolve their problems. But that may not be it. It may be better to think of theory as a *tool* that helps the counselor help the client. *Thus, theory may be most relevant for the counselor—not the client.*

Theory gives counselors a system for making useful meaning of the information they get about clients so that they can say and do things that will be useful to clients. It also helps counselors know how best to relate and respond to clients. Without theory, it is easy to get lost in a sea of information, emotion, and challenging behaviors. Theory gives counselors a systematic way of dealing with the wide range of difficulties clients bring. Thus, choosing a theory involves identifying a theory that makes sense to the counselor and is useful to the counselor in navigating the "wild ride" that is counseling. That said, future research will perhaps more clearly identify specific circumstances when certain models work better for certain clients (Sprenkle & Blow, 2004).

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Show Me Proof: Evidence-Based Treatments and Practice

If you are not confused enough, there is yet another thread in the theory debate that is pulling counselors in the apparent opposite direction of the common factors research: *empirically supported treatments*, generally referred to as *evidenced-based therapies*, counseling models that were developed through research and randomized clinical trials (frequently referred to as RCTs) (Sprenkle, 2002). These should not be confused with *evidence-based practice*, which, although sounding quite similar, refers to a different practice: *using* "evidence" and research to make clinical decisions (Patterson, Miller, Carnes, & Wilson, 2004).

When counselors, licensing boards, or funding institutions refer to counseling models as "evidence-based," they are generally referring to a set of standards that a 1993 task force of the American Psychological Association (APA) established for what was initially called *empirically validated treatments* and later called *empirically supported treatments (ESTs)*, the change underscoring that a treatment is always in the process of being further studied and refined (APA, 1993; Chambless et al., 1996). The APA established several categories for describing empirically supported therapies, and similar categories have been developed by others, all of which are generally considered "evidence-based therapies."

ESTs and Their Kin

ESTs meet the following criteria (Chambless & Hollon, 1998):

- Subjects are randomly assigned to treatment groups.
- In addition to a group receiving the treatment being studied, there must also be
  - a no-treatment control (usually subjects are on a waiting list) or
  - an alternative treatment (for comparison; may be an unspecified approach: "treatment as usual") or
  - placebo treatment.
- Treatment is significantly better than a no-treatment control and at least equally as effective as an established alternative.
- Treatment is based on a written treatment manual with specific criteria for including/excluding clients.
- A specific population with a specific problem is identified.
- Researchers use reliable and valid outcome measures with appropriate statistical measures.

  Efficacious Treatments: Meet the above requirements plus the following (Chambless & Hollon, 1998):
  - Two independent investigations (studies conducted by someone who is not closely involved in the development of the treatment or invested in the outcome of treatment)

  Efficacious and Specific Treatments: Meet the above criteria for Efficacious Treatments plus the following (Chambless & Hollon, 1998):
  - *Superior* to alternative treatments in *at least two* independent studies

  Advantages of ESTs and Efficacious Treatments
  - Greater scientific support
  - Written manuals to guide treatment; highly structured
  - Target a specific population with a specific problem

  Disadvantages of ESTs and Efficacious Treatments
  - Limited applicability: targets a specific and therefore limited population
  - Expensive: counselors need highly specific training in the model *and* need to be trained in a number of models to function effectively in most work environments

Real-World Applications of ESTs

The findings of the APA's 2005 follow-up report on ESTs highlight the necessity for more broadly defined standards of evidence-based treatments (Woody, Weisz, & McLean, 2005).

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This survey indicated that although a higher percentage of ESTs were taught in the classroom, there was a *significant drop in clinical training* in ESTs from 1993 to 2003. When asked to identify the obstacles to clinical training in ESTs, supervisors cited "uncertainty about how to conceptualize training in ESTs, lack of time, shortage of trained supervisors, inappropriateness of established ESTs for a given population, and philosophical opposition" (Woody et al., 2005, p. 9). Arguably, all but perhaps the last of these obstacles are clearly linked to the exact things that make ESTs unique: written treatment manuals and narrowly defined population. Thus, although promising, ESTs have significant practical limitations at this time.

Evidence-Based Practice

More commonly used in the medical field, *evidence-based practice (EBP)* refers to using research findings to inform clinical decisions for the care of individual clients. Patterson et al. (2004) describe five steps in employing EBPs:

Step 1. Develop an answerable question to focus the search for information (e.g., What treatments are most effective for teens who cut to relieve emotional pain?)

Step 2. Search the literature for the best empirical evidence to answer the question (e.g., search digital databases such as PsycINFO and scholar.google.com using key words: "adolescents," "self-harm," "treatment")

Step 3. Evaluate the validity, impact, and applicability of the research to determine its usefulness in this case (e.g., Is the study randomized? Were there comparison groups? What was the treatment effect size? Were the findings clinically relevant?)

Step 4. Determine whether the research findings are applicable to the current client's situation (e.g., What are the potential benefits and risks to applying these findings with this current client? Are there age, ethnicity, class, family system, or other diversity factors that I need to consider?)

Step 5. After implementing the EBP, evaluate the effectiveness in this client's individual case (e.g., How did the client respond? Were there signs of improvement, no change, or worsening?)

In comparison to ESTs, EBP is a practical and practice-friendly approach for using research to enhance the practice of counseling.

Research in Perspective

Counselors need to keep the evidence-based counseling movement in perspective. Almost all research indicates that any counseling is better than no treatment at all: that is one of the major motivation factors behind the common factors movement (Miller et al., 1997; Sprenkle & Blow, 2004). The evidence-based counseling approach refines what we know and aims to develop better and more specific theories; however, this should not be misinterpreted as though *nothing* in the field has ever been researched or studied before. A more fair and realistic assessment is that mental health theories have an established history of meaningful research, and our ability to do so more precisely continually increases. Research courses have been part of mental health curricula from the beginning and are increasingly valued and expanded. A research orientation is not new; however, our ability to conduct more meticulous and useful studies is improving.

Try It Yourself

Find a partner and debate the pros and cons of common factors and evidence-based treatments. Which side is more compelling to you? Why?

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Rock-Paper-Scissors and Other Strategies for Choosing a Theory

Regardless of challenges from the competency and research movements, for most, choosing a counseling theory to work from still compares to the search for love: some preferring the "one and only" and others preferring to "play the field." Those yearning for the perfect mate engage in a focused and passionate pursuit: scanning the Web, reading books, going to seminars, or searching for that *one* theory that shares your beliefs, style, and chemistry, leaving you with a "meant to be" feeling. Others set out with a preference for dating, not wanting to commit to any one theory but instead preferring the "string-free" freedom of being eclectic. Before you rush to join one of these two camps, I am going to caution that neither approach is likely to lead to counseling theory nirvana, immediate competence, or a similar form of bliss. You need to begin by carefully examining research on the role of theory in counseling before declaring your intent. I expect that you will be convinced to proceed with a bit more caution, just as you did after your heart was broken the first time (sorry in advance to those romantic and free-love readers for being a killjoy).

To Be Continued …

"To be continued …": the most dreaded end-of-season conclusion to a favorite television show. Now, I'm doing it to you in a textbook. Sorry. For now, I encourage you to neither be on the prowl for your "match-made-in-heaven" theory nor assume that you can do it all by being wildly "eclectic." Instead, simply focus on understanding the intricacies of each theory—one by one—in the chapters that follow (Chapters 3 to 14). Try to keep an open and curious mind and enjoy getting to learn more about the foundational schools of counseling and psychotherapy.

Note: For those of you who can't wait to know how this ends, you can sneak a peek at Chapters 15 and 16 to learn more about what effective integration looks like.

Questions for Personal Reflection and Class Discussion

1. How would you define a "competent counselor" or "competent psychotherapist"? What life experiences and/or readings have shaped this definition?
2. How do you believe counseling theories are used by mental health professionals in their work?
3. Provide one specific example in which cultural competence would be critical in a counseling situation.
4. What personal strengths do you bring to the counseling encounter? In what ways might you need to grow yourself (the-person-of-the-counselor) to be more effective? How might you pursue such growth?
5. Do you find yourself more drawn to a common factors model or evidence-based treatment model? Where do you think this preference comes from?
6. Which of the common factors was most surprising to you? Why?
7. How do you imagine that research will inform your practice?
8. What are your thoughts about choosing a counseling theory from which to work?
9. What are your thoughts on integrative approaches?

Online Resources

American Counseling Association Code of Ethics
www.counseling.org

American Association for Marriage and Family Therapy Code of Ethics
www.aamft.org

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American Psychological Association Code of Ethics
www.apa.org

American Psychological Association Competency Assessment Resources
www.apa.org/ed/graduate/competency.aspx

CACREP: Council on Accreditation of Counseling and Related Educational Programs: Competency-Based Standards for Counselors
www.cacrep.org

Center for Clinical Excellence: Common Factors
www.centerforclinicalexcellence.com

Empirically Supported Treatment Documents: Links to APA Documents on ESTs
www.apa.org/divisions/div12/journals.html

Heart and Soul of Change: Common Factors
http://heartandsoulofchange.com

National Association of Social Workers Code of Ethics
www.socialworkers.org

National Association of Social Workers Practice Standards for Specialties and Special Populations
www.socialworkers.org/practice/default.asp

SAMHSA Registry of Evidence-Based Programs and Practices
www.nrepp.samhsa.gov

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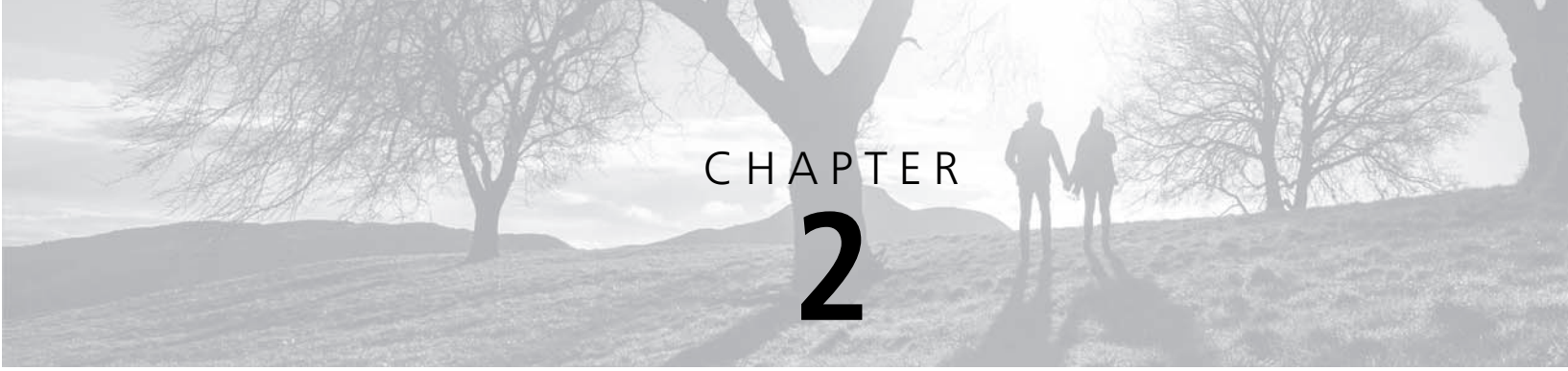

CHAPTER

2

Treatment Planning

Treatment Planning

Shanna was 12 when I met her. She was alone in witnessing her mother die of a stroke three years before. Her aunt tried to take care of her the first year but had to give her up to social services because she did not want the trouble. To be fair, Shanna was trouble. She frequently ran away, talked back, and didn't do her homework. Her foster parents—there were several in the past two years—had similar experiences. So, when I submitted by treatment plan to county mental health, I included the following in my goals:

1. Reduce episodes of running away to none; sustain for three months.
2. Reduce arguing with foster parents to no more than one mild episode per week.
3. Increase completion of homework to 90% every week; sustain for three months.
4. Work through grief related to loss of mother.

My treatment plan was rejected. So, I called the county mental health department to ask how best to revise the plan. The assessor on the other end of the phone said, "You just need to make the last goal measurable." In trying to get her to lighten up, I jokingly said, "Something like count how many tears she cries each week?" To my shock and horror, without skipping a beat, she said, "Yes, that would be perfect." That's when I realized I was dealing with an out-of-control bureaucracy rather than a system that promotes client welfare. Rather than demean my client's loss, I told her to strike the fourth goal from the plan and approve it with the first three. She agreed. I then documented in my notes how I worked on grief to help her let go of the guilt that held her back from building a relationship with her foster parents and kept her from investing herself in school so she could make a life for herself.

However, the anger I felt over the dehumanizing practice of reducing a child's grief to a simple matter of counting tears did not dissipate. So, in an act of rebellion and classic sublimation (if you are curious, see Chapter 3 for definition), I did all that an academic could do to make a difference in the world: I wrote a book (we are a wimpy lot when it comes to revolution). Over the following year, I spent my weekends writing a book that would provide justification for writing goals like "resolve grief related to loss of mother." I figured if it was in the literature, I could argue my case much better the next time a client needed me. In this book, *Theory-Based Treatment Planning for Marriage and Family Therapists*, I developed a *theory-based* approach to treatment planning, a model I developed for helping students conceptualize their cases. It's been almost 10 years since then, and my treatment plan approach has had to evolve to keep up with new demands from third-party payers and revised federal guidelines. In this chapter,

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you are going to learn a more comprehensive model for treatment planning that should enable you to get yours approved for payment the first time you submit—without counting tears.

Creative Planning

Treatments plans are fun and perhaps one of the most creative acts of a counselor. However, they also come with the burden of professional responsibility. As numerous good plans can be developed for any one client, counselors are free to choose—as well as responsible for choosing—a theory and techniques that are the best fit for *this client*, the specific *problem*, and the particular counselor-client relationship. In developing a treatment plan, counselors need to consider the evidence base related to the client issue, client demographics, and theory chosen. Ultimately, a counselor's job is to shepherd an effective intervention process that addresses the client's concerns, and coherent, thoughtful treatment plans are a primary vehicle for demonstrating the ability to do so.

The Brief History of Mental Health Treatment Planning

This section is brief because the history of mental health treatment planning is quite short. The original theorists did not talk or write about treatment planning, and, in fact, if you search the literature, you will not find any published in a form that a managed care company would approve for payment. If the approved approach to treatment planning isn't found in mental health literature, where did it come from? The short answer: the medical field.

The type of treatment planning that the vast majority of counselors must complete in order to receive third-party payment and, arguably, to maintain standard practice of care in the 21st century is derived from the medical model: it's what medical doctors use for medical treatment. Within the field of mental health, Jongsma and his colleagues (Dattilio & Jongsma, 2000; Jongsma, Peterson, & Bruce, 2006; Jongsma, Peterson, McInnis, & Bruce, 2006; O'Leary, Heyman, & Jongsma, 1998) have developed the most extensive models for this form of treatment planning, which is focused solely on clients' medical symptoms and referred to as *symptom-based treatment plans*. Most publications on mental health treatment planning use a similar symptom-based model (Johnson, 2004; Wiger, 2005). The strength of these plans is that they are relevant to those in the medical community; the weakness is that they do not sufficiently help counselors to conceptualize their treatment in useful ways.

For example, if a parent brings a child to counseling who is having tantrums and the counselor develops a plan around the presenting problem (e.g., "reduce child's tantrums to less than once per week") and follows that plan without thoroughly conceptualizing the case from a theoretical perspective, treatment is less likely to be successful. In this particular situation, a systemic assessment will typically reveal that there are marital and/or parenting issues that contribute to the presenting problem. In many cases, I find that doing couples counseling that targets tension in the marriage is the best way to reduce the child's tantrums. The danger of symptom-based treatment planning is that the counselor will *under*utilize counseling theories to conceptualize and overfocus on symptoms. Or, to borrow from the cliché, they are likely to miss the forest because they are focusing on the trees. Arguably, a "good" counselor would not do this; however, today's workplace realities include (a) heavy caseloads, (b) pressure to complete diagnosis and treatment plans by the end of the first session, and (c) highly structured paperwork and payment systems, all of which make it hard for a good counselor to do a good job. Thus, symptom-based treatment planning, although convenient, may not be the best choice for today's practice environments.

In Gehart and Tuttle (2003), we promoted theory-based treatment planning, which involved using theory to generate more clinically relevant treatment plans than the symptom model offers. Berman (1997) developed a similar approach for traditional psychotherapies. The strength of these models was that they include goals that are

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informed by clinical theories. However, after using theory-based plans with new trainees, I discovered that theory-based goals and interventions are easily confused because they use the same theory-based language. Furthermore, it was difficult for most students to address diagnostic issues and clinical symptoms in these theory-based plans because the language of these two systems is radically different. So, I have developed a new, "both/and" model that draws from the best of theory-based and symptom-based treatment plans and adds more recent elements of measurability.

Clinical Treatment Plans

Clinical treatment plans provide a straightforward yet comprehensive overview of treatment. These plans separate out *treatment tasks*, the treatment elements the counselor is responsible for, from *client goals*, the specific aspects of the client's life to be changed.

Clinical treatment plans include the following elements:

- **Introduction**: The treatment plan starts with a brief introduction to the planned modalities (individual, couple, family and/or group), frequency, and expected length of treatment.
- **Treatment Tasks**: Treatment tasks are "standard practice" tasks that the counselor should perform at each stage of counseling, namely the initial, working, and closing phases of counseling. These tasks are informed by theory as well as ethical and legal requirements. These are rarely included in other plans, but spell out standards of practice that are important to consider and document.
- **Diversity**: For each treatment task, the counselor identifies how specifically the counseling process will be adjusted to address diversity issues, such as age, gender, ethnicity, ability, sexual identity, and such. This part rarely goes into a formal plan for reimbursement; however, it is a profound step for becoming a counselor who is competent with cultural and diversity issues—because, although you may technically use the same intervention to develop a counseling relationship with all clients when using a particular theory, you should be altering its implementation when working with a six-year-old girl, fourteen-year-old young man, or an eighty-year-old army veteran.
- **Client Goals**: The key element of all treatment plans, client goals are unique to each client and describe what behaviors, thoughts, feelings, or interactions will be either increased or decreased as a result of treatment. Client goals are derived from the assessment of the presenting problem and are in theory-specific language. These goals are included in virtually all forms of treatment plans in one way or another.
- **Interventions**: Each goal includes two to three interventions that describe how the counselor plans to achieve these goals using the counselor's chosen theory. Interventions may or may not be included in other types of treatment plans.
- **Client Perspective**: The final section describes areas of client agreement and concern with the outlined plan. Increasingly, public mental health agencies include some indication that the client agrees with the plan, often a signature or statement that the plan was shared with the consumer.

However, before you start writing a treatment plan, you should have an idea of what to treat: that is where case conceptualization comes in.

Theory-Specific Case Conceptualization

Taking the time to write a theory-specific case conceptualization is the most important—and, for many, the most difficult—step in the treatment planning process, making it the one some new counselors would prefer to skip. Why? It requires significant reflective and critical thinking; it is *not* formulaic. It will take some time to apply theoretical concepts to your client's actual situation. You will struggle. It most often will *not* be as clear as in the textbook (painful truth: nothing in life is). But in that struggle, you will

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actually learn how to use theory. You will become a competent counselor. Thankfully, you will find some tools in this text to make this process easier. In the "Putting it all together" section for each theory, you will find a template for writing a theory-specific case conceptualization. All of these concepts are described in detail in the "The Viewing: Case Conceptualization" sections of the theory in question. Finally, at the end of each theory chapter you will find a detailed example to give you an idea as to what the final product might look like.

After completing the conceptualization, step back and ask yourself the following question:

- What two to three key patterns emerged in the case conceptualization? These key themes will be the focus of the working phase and possibly the closing phase goals in the treatment plan below. Any potential crisis issues will be the focus of your initial phase goals. Closing phase goals may also be informed by the specific approach's theory of health and normalcy if the theory has such elements. For example, some theories, such as psychodynamic, person-centered, or dialectic behavioral therapy have theoretically defined long-term goals, such as clear ego strength, self-actualization, or trauma resolution. When using such models, counselors begin with these larger goals in mind and design the middle-phase goals to prepare clients for the closing-phase goals.

Treatment Plan Format

Treatment Plan

Date: _____ Case/Client #: _____

Clinician Name: _____ Theory: _____

Modalities planned: ❑ Individual Adult ❑ Individual Child ❑ Couple ❑ Family

❑ Group: _____

Recommended session frequency: ❑ Weekly ❑ Every two weeks ❑ Other: _____

Expected length of treatment: _____ months

Initial Phase of Treatment

Initial Phase Treatment Tasks

1. Develop working relationship. *Diversity considerations:* [Describe how you will specifically adapt your approach to be sensitive to client diversity when developing the counseling relationship; this may include respecting cultured and gendered norms for emotional expression.]

   Relationship-building approach/intervention:

   a. _____

2. Assess individual, systemic, and broader cultural dynamics. *Diversity considerations:* [Describe how you will adjust assessment based on cultural, socioeconomic, sexual orientation, gender, and other relevant norms.]

(*continued*)

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Assessment strategies:

a. _____

b. _____

Initial Phase Client Goals: Manage crisis; reduce distressing symptoms

1. ❑ Increase ❑ Decrease _____ (personal/relational dynamic using terms from theory) to reduce _____ (symptom).

   Interventions:

   a. _____

   b. _____

Working Phase of Treatment

Working Phase Treatment Task

1. Monitor quality of the working alliance. *Diversity considerations:* [Describe how you monitor the client's ongoing sense of connection with counselor and how you will specifically adapt monitoring and/or relationship based on client age, gender, cultural, sexual orientation, socio-economic, etc.]

   a. *Assessment Intervention*: _____

Working Phase Client Goals *(2–3 Goals):* Target individual and relational dynamics using theoretical language (e.g., decrease avoidance of intimacy, increase awareness of emotion, increase agency, etc.)

1. ❑ Increase ❑ Decrease _____ (personal/relational dynamic using terms from theory) to reduce _____ (symptom).

   Interventions:

   a. _____

   b. _____

2. ❑ Increase ❑ Decrease _____ (personal/relational dynamic using terms from theory) to reduce _____ (symptom).

   Interventions:

   a. _____

   b. _____

3. ❑ Increase ❑ Decrease _____ (personal/relational dynamic using terms from theory) to reduce _____ (symptom).

   Interventions:

   a. _____

   b. _____

(*continued*)

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Closing Phase of Treatment

Closing Phase Treatment Task

1. Develop aftercare plan and maintain gains. *Diversity considerations*: [Describe how you will access resources in the communities of which they are a part to support them after treatment ends.]

   Intervention:

   a. _____

Closing Phase Client Goals (*1–2 Goals):* Determined by theory's definition of health and normalcy

1. ❑ Increase ❑ Decrease _____ (personal/relational dynamic using terms from theory) to reduce _____ (symptom).

   Interventions:

   a. _____

   b. _____

2. ❑ Increase ❑ Decrease _____ (personal/relational dynamic using terms from theory) to reduce _____ (symptom).

   Interventions:

   a. _____

   b. _____

Client Perspective

Has treatment plan been reviewed with client: ❑ Yes ❑ No; If no, explain: _____

Describe areas of Client Agreement and Concern:

_____, _____ _____, _____

Clinician's Signature, Intern Status Date Supervisor's Signature, License Date

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Writing Useful Treatment Tasks

Treatment tasks are generally the easiest part of the treatment plan to develop because they are the most formulaic. Each theory has its own language and interventions for describing how to create a counseling relationship, and a good plan should reflect these differences. For example, a humanistic counselor focuses on the affective quality of the relationship, while a counselor using a cognitive counseling would have a more pragmatic and problem-focused approach.

Initial Phase Treatment Tasks

Perhaps not surprisingly, counselors have the most tasks in the initial phase of treatment. This is when the counselor establishes the foundation for counseling.

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Virtually all theories include in some form these two initial counselor tasks early in counseling:

- Establish a counseling relationship
- Assess individual, family, and social dynamics

Although each theoretical approach has different ways to approach these tasks, the cross-theory similarities make it easy for counselors to conceptualize this early phase of treatment.

Working Phase Treatment Task

In the working phase, the primary task is to keep the ball rolling. Counselors need to monitor to ensure that they maintain a strong rapport with clients. As counseling progresses, the counseling relationship can be weakened by numerous obvious and not-so-obvious factors, including lack of progress, a necessary confrontation, a counselor's ill-timed self-disclosure, a misinterpreted comment, a random remark by a stranger, or the outcome of a Google search. Thus, counselors must continue to monitor the relationship to ensure that there is a solid working foundation for the treatment plan. Monitoring of the relationship should always be done by observation and verbally "checking in" every few weeks.

Closing Phase Treatment Tasks

Simply put, the primary task of the closing phase is for counselors to make themselves unnecessary in clients' lives. During this phase of counseling, counselors work with clients to develop aftercare plans that include identifying (a) what they did to make the changes they have made, (b) how they will maintain their success, and (c) how they will handle the next set of challenges in their lives. Each counseling model has different ways of doing this, but there is a cross-theoretical consistency as well as a consistent logic to this task that is useful in most counseling situations. When done well, clients leave counseling feeling better able to handle the inevitable problems that will continue to arise in their lives. As systemic practitioner John Weakland reportedly stated, "Clients come in experiencing the same damn problem over and over. Therapy is successful when life is one damn problem after another" (Gehart & McCollum, 2007, p. 214).

Diversity and Treatment Tasks

For each treatment task, you should also note how you will address diversity issues, such as culture, ethnicity, race, sexual orientation, gender orientation, religion, language, ability, age, gender, and so on. For example, with almost every client, you will need to adjust your relationship style, from slightly to significantly, for some form of diversity, such as age, ethnicity, or gender. Similarly, any assessment of functioning should always take into consideration diversity variables.

In virtually all cases, diversity considerations can address gender, age, ethnicity, and socioeconomic status. You don't need to address all of these every time, but you should specifically identify at least one significant one for each treatment task. Additionally, counselors can also note here how to address *counselor-client differences* in terms of these diversity factors.

Examples of how diversity may be addressed in treatment tasks:

- Use of humor with teens and men
- More formal, respectful relational style with immigrants or clients from ethnic backgrounds that prefer such relations with professionals (*respecto* with Latino clients)
- Use of *personalismo* with Hispanic/Latino clients
- Including spirituality and religious beliefs and resources
- Including more extended family or tribe members with clients who come from backgrounds where the extended family/tribal system is the primary system
- Use of present-focused, problem-focused approaches with clients who do not value exploring the past

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- Using interventions, assessments, and questions that enable Asian clients to avoid shameful discussions
- Including culturally appropriate resources and persons in therapy
- Assessing family of choice with gay, lesbian, bisexual, or transgendered clients
- Accounting for the stress of marginalization and discrimination in assessment

If this seems like a daunting task, it is. I believe it is impossible to "master" diversity issues as a counselor. Instead, it is an ever-unfolding journey of developing new competencies in this area; each client, friend, family member, and stranger in your life offers you an opportunity to learn more. I hope you take them up on the offer each time. However, I realize you may want something more concrete to help you get started. One place to start learning about how to address diversity in counseling is this book. Each theory chapter (Chapters 3–14) includes a section that describes some of the ways the theory can be used with select ethnic, racial, and sexually diverse groups. The case studies in this book also have examples for you to use. Additionally, for ethnicity and religion, McGoldrick, Giordano, and Garcia-Preto (2005) describe the cultural norms for emotional expression and communication, typical family dynamics, and common clinical issues for 53 different ethnicities. Furthermore, counselors should also be familiar with the basics of working with children (Adler-Tapia, 2012), men (Good & Brooks, 2005), and older adults (Knight, Nordhus, & Satre, 2003). As you meet clients with more specific diversity issues—such as an unfamiliar religion, disability, or chronic medical condition—it is an ethical responsibility for counselors to educate themselves about the client's circumstances to better understand how best to engage and support them.

Try It Yourself

Describe how a counselor would attend to your unique diversity factors to: a) create a counseling relationship, and b) assess your individual, family, and social dynamics.

Client Goals

I am going to tell you the truth: writing good client goals is not always easy. Writing excellent ones can be a challenge. Writing goals reveals the clarity of your thinking, namely, your ability to conceptualize and understand the complex interplay between your client's presenting problem, personal dynamics, relational dynamics, and manifest psychiatric symptoms. Meaningful client goals strategically target two to three key threads that link these seemingly unrelated dynamics and issues. If you ever tried to open a large bag of flour (or sugar, cat litter, bird seed, etc.) sealed with a braided thread, you know how this works. When you find the right thread to pull on, you achieve your goal effortlessly and quickly. If you can't find the right thread, nothing moves, you get wildly frustrated, and you end up cursing when you finally use scissors to get the job done (at this point, the flour explodes in your face to further your humiliation—if you are laughing, I know you've been there, too). Similarly in counseling, when you know which threads to pull on, things go smoothly. When you don't, things don't move, and frustration ensues. To help you find the right thread, you can use the following goal writing worksheet.

Goal Writing Worksheet

When you are ready to write client goals for your treatment plan, begin by completing the goal writing worksheet. It combines (a) the client's description of the problem and (b) findings from the case conceptualization to help you quickly identify the key personal and relational dynamics that should be targeted for change. These become the foundation for the treatment plan.

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Goal Writing Worksheet

Presenting Problem: These are used to help identify problem *dynamics*

What does the client say is the problem(s)? Use the client's words and phrases as much as possible.

1. _____

2. _____

3. _____

4. _____

Dynamics: These are used to write your *goals*

Develop a case conceptualization based on "The Viewing: Case Conceptualization" section of each theory chapter or use the integrative case conceptualization in Chapter 16. Identify two to four of the most salient problematic psychological or relational dynamics from the case conceptualization; these are the dynamics that are most likely to be contributing to the client's presenting problem. In some cases, you will see that certain dynamics overlap or are related; in these situations, try to summarize these overlapping dynamics into one point below.

1. _____

2. _____

3. _____

Symptoms

Identify two to four of the most salient psychological symptoms or issues (e.g., depression, anxiety, substance use, conflict with loved ones, isolation, loss of interest, hallucinations). List these below.

1. _____

2. _____

3. _____

Put It All Together

This keeps you honest: Do all the pieces fit together?

Dynamic: *List the salient psychological and relational dynamics below.*	**Problem:** *Identify which of the client's presenting problems this dynamic relates to.*	**Symptom:** *Identify which symptom(s) is(are) likely to improve if the dynamic improves.*
1.		
2.		
3.		

Note: If for any reason you have symptoms that don't seem to be related to the dynamics you chose, review your case conceptualization again.

(continued)

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Evidence-Based Practice (Optional): Helps you determine theory and technique

Use PsyclNFO or a similar search engine to do a review of the research literature related to (a) the client's presenting problem, (b) diagnosis, (c) personal demographics/diversity factors, and/or (d) your intended counseling approach. Describe the key interventions, techniques, or guidelines below.

1. _____

2. _____

3. _____

Based on the most salient dynamics and evidence base as well as your client's needs, which theory and/or techniques do you plan to use with this case?

_____

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Once you have identified the key dynamics, you should review the research literature to identify treatments that may have particular relevance for your client. For example, if you are working with a teen struggling with substance abuse issues, a quick PsycINFO or Google Scholar search will reveal that there are numerous studies showing that systemic family treatments are most effective with this population. In this case, you will want to include some family sessions in your plan.

The Goal Writing Process

The hardest part is always writing the goal. There are not any clear rules that work for every situation because each client is unique. However, there are some guidelines that can be useful.

Guidelines for Writing Useful Goals

- **Start with a Key Concept/Assessment Area from Theory of Choice:** Begin the goal with "increase" or "decrease" followed by a description using language from your chosen theory as to what is going to change.
- **Link to Symptoms:** Describe what symptoms will be addressed by changing the personal/relational dynamic.
- **Use Client's Name:** When you use the client's name (or equivalent confidential notation), you ensure that it is a unique goal rather than a formulaic one.

Anatomy of a Client Goal

"Increase/Decrease" + [theoretical concept/assessment area] + "to reduce" + [symptom]

Part A | Part B

Each part has a different function:

Function of Part A and Part B of Goal Statement

Part A: Gives the counselor a clear focus of treatment that fits with the theory of choice.

Part B: Provides third-party payers with a clear description of how psychiatric symptoms will be affected.

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Part A is most useful to the counselor for conceptualizing treatment; Part B is most useful to third-party payers who require a medical model assessment. When counselors write goals that address both A and B, they allow themselves maximum freedom and flexibility to work in their preferred way while translating their work so that third-party payers get their needs met as well.

Sample Goals:

- *Increase* positive self-talk about body *to reduce* binging and body image distortion. (cognitive-behavioral)
- *Reduce* compliance to socially imposed "shoulds" related to making others happy *to reduce* AF sense of hopelessness and depression. (person-centered)
- *Increase* frequency of social interaction and reengagement in music and sports hobbies *to reduce* severity of depressed mood. (solution-focused)

Initial Phase Client Goals

During the initial phase of counseling (in most cases the first one to three sessions), client goals generally involve stabilizing crisis symptoms, such as suicidal and homicidal thinking; severe depressive or panic episodes; stabilizing eating and sleeping patterns; managing child, dependent adult, and elder abuse issues; addressing substance and alcohol abuse issues; and stopping self-harming behaviors, such as cutting. In addition to stabilizing crisis issues, some theories have specific clinical goals that should be addressed in the initial phases. For example, solution-based counselors begin working on clinical symptoms in the first session by setting small, measurable goals toward desired behaviors, as well as by increasing clients' level of hope (O'Hanlon & Weiner-Davis, 1989).

Working Phase Client Goals

Working phase client goals address the dynamics that create and/or sustain the symptoms and problems for which clients came to counseling. These are the goals that most interest third-party payers. The secret to writing great working phase client goals is framing the goal *in the theoretical language* used for conceptualization and then linking this language to the psychiatric symptoms. When counselors state the goal using theoretical language, it enables them to document a coherent treatment using their preferred language of conceptualization rather than language that is geared for those prescribing medication.

For example, when a client is diagnosed with depression, many counselors include a goal such as "reducing depressed mood." Let's not kid ourselves: a person does not need a master's degree and 2,000 to 4,000 hours of training to come up with such a goal. This medical model, symptom-based goal does not provide clues as to what the counselor will actually do. Furthermore, all documentation for the case will need to monitor the client's level of depression each week. In contrast, a clinical client goal should address the theoretical conceptualization that will guide the reduction of depression. Some examples include the following:

- *Psychodynamic:* Reduce rationalization to increase ability to directly experience emotions and reduce depressed mood.
- *Humanistic:* Increase ability to experience authentic emotions in the present moment to reduce depressed mood and increase sense of personal agency.
- *Cognitive-behavioral:* Reduce negative self-talk related to social acceptance to increase positive mood.
- *Narrative:* Reduce influence of family's and societal evaluations of self-worth to increase sense of autonomy and reduce depressed mood.

Each of these goals addresses a client's depressed mood and also provides a clear clinical conceptualization and sense of direction, therefore being much more useful to counselors than the medical goal of "reduced depressed mood."

Closing Phase Client Goals

Closing phase client goals (a) address larger, more global issues that clients bring to counseling and/or (b) move the client toward greater "health" as defined by the

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counselor's theoretical perspective. The former type of goals often takes the form of clients presenting with one issue, perhaps marital discord, and then later wanting to also address their parenting issues in the later stages of counseling. Similarly, often a client may present with depression or anxiety and in the later phase want to address relationship issues or an unresolved issue with their family of origin. Also, a couple may present with several pressing issues, such as conflict and sexual concerns to be treated in the working phase, and in the later phase want to examine more global issues, such as redefining their identities and relational agreements.

The second type of client goal in the later phases is driven by the counselor's agenda. Some theories, such as humanistic and psychodynamic, have very clearly defined theories of health that counselors work toward. Other theories, such as systemic and solution-focused therapies, have less clearly defined long-term goals and theories of health for people. Thus, closing phase goals often include an agenda item that clients may not have verbalized. For example, in humanistic counseling, increased authenticity is a long-term goal that is embedded in the theory that should be included in long-term goals for clients. With such a general goal, it helps to add more detail, such as "increase sense of authenticity *in the marriage OR in career OR in social interactions*." The more specific the goal, the more likely it is to be achieved.

Writing Measurable Goals

Many third-party payers require goals to be "measurable," meaning that somehow the client and counselor will know when the goal is achieved. Starting the goal with "increase/decrease" helps in this effort. In addition, some third parties want counselors to specify exactly what the criterion will be to determine if the goal has been met. To meet this requirement, you may use the following:

Measure: Able to sustain _____ for period of _____❑ weeks ❑ months.

Examples:

- Able to sustain positive mood for period of 2 ❑ weeks ☒ months.
- Able to sustain positive relational interactions for period of 2 ❑ weeks ☒ months.
- Able to sustain sobriety for period of 6 ❑ weeks ☒ months.
- Able to sustain C grade point average for period of 4 ❑ weeks ☒ months.

Try It Yourself

Identify three personal goals and make them measurable.

Writing Useful Interventions

The final element of treatment plans is including interventions to support each counseling task or client goal. Once you have conceptualized treatment and identified counseling tasks and client goals, identifying useful interventions is generally quite easy (thankfully). The interventions should come from the counselor's chosen theory and be specific to the client.

Guidelines for Writing Interventions

- **Use Specific Interventions from Chosen Theory:** Interventions should be clearly derived from the theory used to conceptualize counseling tasks and client goals. If

(*continued*)

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an intervention from another theory is integrated, the modifications should be clearly spelled out.

- **Make Specific to Client:** Use confidential notation (e.g., AF for adult female and AM for adult male) to make the goal as specific and clear as possible. For example, "Increase AF's ability to express emotions effectively with AM."
- **Include Exact Language When Possible:** Whenever possible, counselors should use the exact question or language a counselor would use to deliver the intervention (e.g., "On a scale from 1 to 10, how would you rate your current level of happiness?").

Do Plans Make a Difference?

Now that you know how to create a detailed treatment plan, I want to also let you in on a little secret: like most things in life, counseling rarely goes according to plan. Life happens, new problems arise, original ones lose their importance, and new stressors change the playing field. Does that make plans useless? Absolutely not. Treatment plans help counselors in numerous ways, many of which are not obvious at first:

- Treatment plans help counselors think through which dynamics need to be changed and how.
- Treatment plans provide counselors with a clear understanding of the client situation so that they can more quickly and skillfully address new crisis issues or stressors that arise.
- Treatment plans give counselors a sense of confidence and an increased clarity of thought that makes it easier to respond on the spot to new issues.
- Treatment plans ground counselors in their theory as well as understanding of how their theory relates to clinical symptoms.

All this is to say, do not be surprised when counseling does not go according to plan; instead, expect it. And know that the time you take to create a treatment plan makes you much better able to respond to the unplanned.

Questions for Personal Reflection and Class Discussion

1. Do you like the idea of writing a treatment plan? Why or why not?
2. Describe the possible link between treatment tasks and the common factors model?
3. Some theories have predefined long-term goals that relate to their definition of mental health, such as self-actualization in humanistic approaches. Do you like this idea or not? Why or why not?
4. Describe an example of how you might modify your communication based on a client's:
   a. age.
   b. gender.
   c. ethnicity.
   d. sexual orientation.

Online Resource

Symptom-Based Treatment Planners
www.jongsma.com

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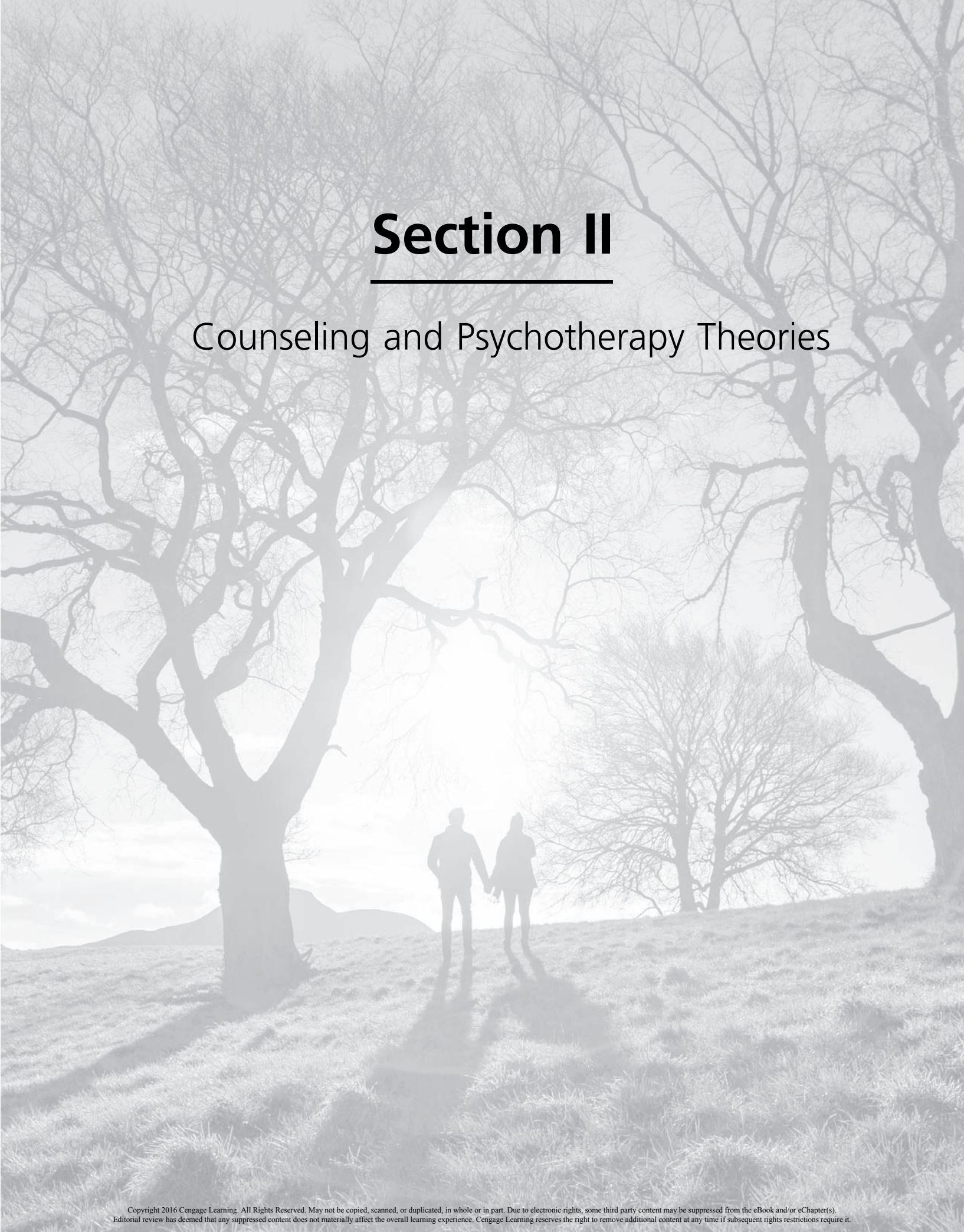

Section II

Counseling and Psychotherapy Theories

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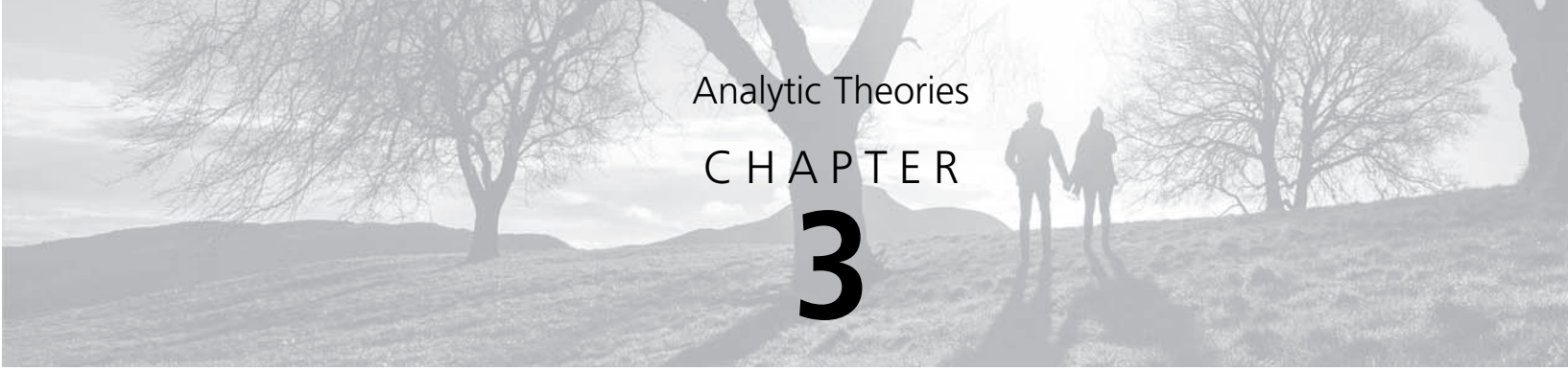

Analytic Theories

CHAPTER

3

Psychoanalytic and Psychodynamic Counseling and Psychotherapy

Analysis does not set out to make pathological reactions impossible, but to give the patient's ego freedom to decide one way or another.

—Sigmund Freud

Lay of the Land

Over a century in development, psychoanalytic and psychodynamic theories include a wide range of practices, including "blank-slate" analysts whose clients free-associate on a couch, empathetically engaged counselors who address early childhood relationships, relationally oriented therapists who co-construct interpretations with clients, and brief psychodynamic practitioners who use manualized treatment with substance abuse. All these—along with Jung's analytic (Chapter 4) and Adler's individual psychology (Chapter 5)—are considered *depth psychologies* because they explore the *unconscious mind*, which is conceptualized as "deeper" than the conscious mind. As they are not only "deep" but also have the longest history of all psychotherapy approaches, let me warn you from the outset that this chapter is rich and full. So let's start at the beginning: with Freud himself.

The original psychotherapy, Freudian *psychoanalysis* is the root of all psychodynamic approaches, with ego psychology, object relations, self psychology, relational, and intersubjectivity theories being the most direct descendants. Although there is some debate over the terms, everyone agrees that *psychoanalysis* always refers to Freud's original approach, and most agree that it describes long-term counseling with multiple weekly sessions in which an analyst analyzes a person's personality using ego psychology, object relations, self psychology, or a relational approach. In psychoanalysis, the analyst is more likely to use a blank-slate approach, often uses a couch, and typically does not engage clients with warmth—an often mocked approach in Woody Allen movies and other Hollywood films. For better or worse, this form of treatment in contemporary contexts is increasingly rare, and is most common in major metropolitan areas.

In contrast, psychodynamic therapy or counseling refers to a more standard, shorter-term (but typically still long), one-session-per-week outpatient counseling

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approach that addresses a specific presenting problem, such as depression or anxiety, rather than the general project of personality analysis. To keep you thoroughly confused, ego psychology, object relationship, self psychology, and relational psychoanalysis can be used for either psychoanalytic or psychodynamic approaches. And if that wasn't complex enough, "analytic" and "psychodynamic" are sometimes also used to refer to the work of Carl Jung (Chapter 4), who was a contemporary of Freud's.

In this chapter, I will introduce you to the more influential psychoanalytic and psychodynamic approaches and try to help you keep them straight. Since the counseling processes for five of the major schools—Freudian drive theory, ego psychology, object relations, self psychology, and relational analysis—share many similarities and are often integrated by "psychodynamic" counselors, these will be discussed in the same section, with differences highlighted throughout so that you can directly compare approaches. Emphasis will be placed on object relations, self psychology, and relational psychology, which are more common approaches in contemporary practice. A quick glance of what's ahead:

- *Psychoanalysis:* Based on Freud's original theories, classic psychoanalysis is a relatively rare but still practiced approach that focuses on analysis of innate drives and transference issues.
- *Ego psychology:* Similar to Freudian theory in terms of the working relationship, ego psychology focuses on analysis of how the ego uses defense mechanisms to manage innate drives.
- *Object relations theories:* Using a more empathetic and warmer counseling relationship, object relations theorists focus on repairing the client's early "object" and relational patterns, often by promoting corrective emotional experiences in the counseling relationship. There are several schools of object relations theory, each using a unique system of analysis; however, they can generally be divided into schools that (a) integrate drive theory and (b) are purely relational.
- *Interpersonal analysis:* Related to object relations, Sullivan's (1953, 1954) interpersonal analysis is unique in that the analysis process relies heavily on observable data and focuses almost exclusively on interpersonal interactions rather than unconscious processes.
- *Self psychology:* Based on the work of Kohut, self psychology involves empathic immersion in the client's inner world, analysis of selfobjects, and a focus on building self-esteem.
- *Relational and intersubjectivity theories:* Recent approaches that emphasize the intersubjective nature of reality and employ a more collaborative counseling relationship, including the co-construction of interpretations with clients (Stolorow, Brandschaft, & Atwood, 1987).
- *Brief psychodynamic theories:* Time-limited, evidence-based approaches that have been demonstrated effective with depression and substance abuse.

Basic Psychodynamic Assumptions

The vast majority of psychodynamic theorists share the following basic assumptions (Greenberg & Mitchell, 1983; Mitchell & Black, 1995; St. Clair, 2000):

- A person's history affects present behaviors and relationships.
- There is an unconscious mind that exerts significant influence over present behavior.
- The personality is structured into various substructures, such as ego, id, and superego.
- A person's personality is significantly impacted by early relationships in life, especially with one's mother or primary caretaker.
- Insight into one's personality and internal dynamics can help resolve various psychopathologies.
- Clients *project* onto the counselor interrelational patterns from earlier unresolved issues, most often with the clients' parents; the *transference* of these patterns can be analyzed and used to promote change in the counseling relationship.

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Psychodynamic Theory

In a Nutshell: The Least You Need to Know

At its most basic level, psychodynamic theory is about analyzing an individual's personality—characteristic habits of mind—to better understand how these dynamics affect the presenting problem and general quality of life. Psychoanalytic and psychodynamic approaches share the basic practices of (a) analyzing or conceptualizing personality structures and functioning, (b) fostering client insight into their personality dynamics, and then (c) working through these insights toward action. The different schools vary in the quality of the counseling relationship (e.g., neutral vs. empathetic) and the preferred concepts for case conceptualization (e.g., defense mechanisms, ego/id/superego). For example, Freudian drive theorists and ego psychologists use a more dispassionate counseling relationship to encourage and use projection to promote change, whereas object relations, self psychologists, and intersubjectivity theorists use more empathy and warmth to create a relationship that can foster corrective experiences. The differences between major schools are summarized below.

	Schools					
	Drive Theory	Ego Psychology	Object Relations	Self Psychology	Interpersonal	Relational/ Intersubjectivity
Theorist	S. Freud	A. Freud, Erickson, Horney	Kernberg, Klein, Fairbairn, Mahler, Winnicott	Kohut	Sullivan	Mitchell, Greenberg, Stolorow
Focus of Analysis	Drive theory; id; instincts	Ego; defense mechanisms	Intrapsychic representations of caregivers	Relationship with self and selfobjects	Observable interactions; self system	Interpersonal world; relational matrix
Root Cause of Problems	Conflicts between id and superego	Defense mechanisms used to manage infantile drives	Pathological internal object relations	Distorted images of self	Keeping elements of interpersonal interactions out of awareness	Distorted expectations of interpersonal world
Mechanism of Change	Making unconscious conscious	Developing more mature defense mechanisms; increase ego strength	Integration of good and bad in objects; release bad objects from subconscious; realistic view of others	Developing a more realistic self-image and sense of self-worth	Developing the ability to maintain healthy interpersonal relations	Developing more realistic expectations and interpretations of relationships
Client–Counselor Relationship	Detached expert; blank slate for client	Detached expert; blank slate for client	Empathetic; uses relationship to reflect on object relations patterns	Empathetic; uses mirroring to help restore self-image	Uses relationship to explore interpersonal dynamics	Uses relationship to explore interpersonal relationship patterns
Commonly Used Techniques	Free association; dream analysis	Analysis of defense; free association; dream analysis	Analysis of early relationships, present relationship with counselor and others	Analysis of selfobject relations; mirroring; empathy	Analysis of behaviors in interpersonal relationships	Exploring client's experience of the relationship with counselor

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The Juice: Significant Contributions to the Field

If you remember one thing from this chapter, it should be …

Transference and Countertransference

Transference A classic psychoanalytic concept that has remained central to virtually all schools, *transference* refers to when a client projects on the counselor attributes that stem from unresolved issues with primary caregivers; therapists use the immediacy of these interactions to promote client insight and work through these conflicts (Kernberg, 1997; Luborsky, O'Reilly-Landry, & Arlow, 2008). The process of transference reveals unconscious templates that clients bring to relationships over and over again. For example, if a client had a critical parent, the client is likely to interpret silence, neutrality, and vague comments as critical. In extreme cases, without repeated, enthusiastic, over-the-top expressions of verbal confirmation (*i.e., "you're amazing, fantastic—the best* client I *ever* had"—and, no, such statements are not appropriate in counseling), these clients will always feel criticized and/or looked down on and will often desperately seek approval from the analyst.

Drive theorists and ego psychologists encourage transference by maintaining a strict neutral stance that encourages clients to project unresolved issues onto the counselor; the analyst can then interpret these for the client. For example, the analyst may analyze transference by stating, "When I sit here quietly listening, you seem to think that I am judging you to be inadequate, much the same way your father used to do when you were little." In object relations, self psychology, and relational approaches, the counselor uses transference slightly differently because they use a more empathetic relationship rather than neutrality to build their relationships with clients. When transference happens in these relationships, the counselor discusses the transference patterns with the client and explains how it emerged in the current relationship: "You seem to think that my quietly listening implies that I am somehow judging you. Would it surprise you to know that I am not? I am simply listening intently." Psychoanalysts also vary on their opinion about whether a "real" nontransference relationship is possible in treatment or whether all interactions are inherently a form of transference, with some arguing that even a positive therapeutic alliance "reflect(s) transference dispositions stemming from a normally achieved trusting relationship between the infant and the mother" (Kernberg, 1997, p. 10).

Recent scholars have added an important caveat to analyzing transference: the client might just be right! In most cases, there is usually a grain of truth in any perception (Gill, 1982). Thus, analysts should not consider all client perceptions and reactions as simply transference; in most cases, the client's perspective captures certain aspects of reality. In addition, relational theorists maintain that the analyst's personality unavoidably influences the client's transference: the analyst *cannot not* affect how the client behaves (Greenberg & Mitchell, 1983). Furthermore, analysts recognize "the concept of 'resistance' as potentially fostering an adversarial relation between patient and analyst, and imposing the analyst's views on the patient" (Kernberg, 1997, p. 9). The process of sorting transference out from accurate description becomes particularly confusing when gender, age, culture, economic, educational, and other diversity issues are taken into consideration. What is accurately perceived as respectful in one culture (e.g., looking someone in the eye when you speak) is considered exceptionally rude in another; such minor differences quickly cascade into a series of misinterpretations on the part of both parties. Thus, it is imperative that counselors be cautious when examining transference, considering the contrasting of their gender, sexual orientation, culture, and economic status and that of the client's.

Countertransference As if matters were not complex enough, counselors also need to consider the issue of *countertransference*. Countertransference refers to when counselors project back onto clients, losing their therapeutic neutrality and having strong emotional reactions to the client. The understanding of countertransference has broadened over the years to include not only the analyst's problematic unconscious projections but also the

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total emotional reaction (Kernberg, 1997). Thus, countertransference can be used in two basic ways, with different schools of psychoanalysis emphasizing one over the other:

- *Countertransference as unconscious projection:* Especially early in training or around a personal issue for the counselor, the countertransference reaction represents an unconscious projection on the part of the analyst that needs to be explored in supervision, and it is often inappropriate to discuss with clients.
- *Countertransference as conscious experiencing of the other:* If the counselor has self-awareness and can accurately sort out the sources of countertransference, it can be used to help the counselor and client better understand how others experience the client and the reactions the client may trigger in others (Luborsky et al., 2008). In this case, countertransference is used with the client to promote insight.

More traditional approaches, such as ego psychology and drive-theory–based object relations, focus primarily on the client's transference, with less focused attention on the analyst's countertransference. In marked contrast, "interpersonal psychoanalysis gives almost symmetrical [equal] attention to transference and countertransference," giving it a more central role in the process of assessment and treatment (Kernberg, 1997, p. 7).

Corrective Emotional Experience Once transference and countertransference patterns have been carefully considered and assessed, relationally focused analysts use this information to provide clients with a *corrective emotional experience* in which the analyst responds differently than the client experienced in childhood to facilitate resolution of an inner conflict. For example, if a client interprets the analyst's refusal to vociferously agree as an aggressive stance, the analyst can use the opportunity to help the client understand that her neutral stance is not an attack but simply another means of showing support and interest.

Self-Assessment Questions to Manage Transference and Countertransference

- What does the client perceive in me *specifically*: an attitude, emotion, behavior, or a thought?
- What behaviors, comments, nonverbals is the client responding to?
- Which elements of the client's experience are accurate descriptions of what is happening?
- Which elements of the client's experience seem to be related to one of the client's prior relationships or relationship with a caregiver?
- Are there differences between us that might explain the client's perception of me, such as age, gender, culture, sexual orientation, education, and so on?
- Do I have any inner emotional reaction to the client's transference? Do I feel angry, insulted, or self-righteous? Or am I able to maintain a calm, nonreactive empathy?
- Do I have any countertransference issues that I am aware of? May there be some that I am not aware of?
- Who does this client remind me of most? How do I react to that person? Is that repeating here?
- Is there anyone in the client's life who might also have a response similar to the response I am having? How does that person respond to the client? How can I use my response to provide a more effective response?

Try It Yourself

Find a partner and discuss a prior role-play situation. Describe any transference or countertransference that may have occurred. Use these questions to guide you in your discussion.

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Rumor Has It: The People and Their Stories

Drive Theory

Sigmund Freud Born into a Jewish wool merchant family in 1856 in the Czech region of the Austrian Empire, Sigmund Freud developed the first psychoanalytic theory and was the first to use the "talking cure" that is common today. Most would claim that he is the grandfather of all the ideas in this book. Although some of his concepts have fallen out of favor and many of his practices are inappropriate for current practice contexts, the majority of his ideas—such as the unconscious, transference, and defense mechanisms—are still at the heart of modern counseling practice and current understandings of the human psyche.

Freud grew up in Vienna in the late 19th century, which was an intellectual center of Europe and home to many of the greatest thinkers of the 19th and 20th centuries (you will notice that it is home to many of the people in this book and the related text *Mastering Competencies in Family Therapy*). He was married to Martha Mernays for 53 years, and they had six children together, the youngest of whom was Anna, who became a well-known ego psychologist (see below). After graduating from high school in 1873, he began studying neurology at the University of Vienna under the mentorship of Ernest Wilhelm von Brüke, who had recently developed the concept of *psychodynamics*, proposing that psychological processes are a flow of energy that follows principles similar to other dynamic physical systems. After finishing a doctoral dissertation on the neurology of fish, Freud's career took a fateful turn when he received a fellowship to study with Jean Martin Charcot, a French hypnotherapist who studied hysteria (now known as somatization disorder), a disorder in which a person has a physical symptom with no identifiable physical cause; thus, a psychological cause is assumed to be the origin. This experience shifted Freud's research to psychopathology, and, as we know, the rest is history (but since this is a textbook, I will continue the story anyway).

Unlike Charcot, Freud found free association (see section "Free Association") and dream analysis to be more effective means for curing psychopathology. His pioneering work led him to theorize that there was an *unconscious mind* that played a significant role in the development and curing of psychological problems; this theory is still generally accepted by the vast majority of psychologically oriented professionals today. His other significant theories include the psychosexual theory of development, the structures of the personality (id, ego, and superego), and drive theory. He was a prolific author, with some of his major works including *The Neuropsychoses of Defense* (1974d), *Studies on Hysteria* (1974e), *The Interpretation of Dreams* (1974b), *Three Essays on Sexuality* (1974f), *On Narcissism* (1974c), and *The Ego and the Id* (1974a).

In 1902, Freud formed an informal discussion group, the *Mittwochsgesellschaft* (Wednesday Society), which met on Wednesdays in Freud's apartment to discuss emerging psychological theories and eventually became the Viennese Psychoanalytic Society. This group included Alfred Adler, whose ideas were more practical and family-focused (see Chapter 5), and Carl Jung, whose ideas were more spiritual and cross-cultural (later in this chapter); both men parted ways with Freud to pursue their own counseling theories and methods. Historians debate whether they were more "students" or "colleagues" of Freud; however, it seems fair to say that if you did not agree with Freud, you were not invited to afternoon coffee or to join his circles, and there are numerous accounts of feuds with his colleagues and students. Many rumors about Freud abound; some of the better-documented ones include an affair with his client/sister-in-law Anna O., his own numerous phobias and psychosomatic disorders, and his experimentation with cocaine as an antidepressant and general panacea.

When the Nazis came to power in Germany in 1933, they burned Freud's writings. When they annexed Austria in 1938, Freud fled that June, reportedly with the help of a sympathetic Nazi officer who was a fellow physician and valued Freud's work. Freud and his family settled in Hampstead, London. After numerous failed operations on his oral cancer, Freud convinced his personal physician to assist him in suicide in September 1939.

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Ego Psychology

Anna Freud Freud's youngest daughter, Anna Freud, built on her father's work on the id and drive theory but added analysis of ego functioning and defense mechanisms; thus, her work is referred to as *ego psychology*. Working primarily with preschool children in London, Anna identified ten defense mechanisms, extending the work begun by her father. In significant departure from her father, she also recognized that motivation can come from external sources, not just internal drives.

Erik Erickson A student of Anna Freud and ego psychologist, Erik Erickson's most significant contribution was an eight-stage model of *psychosocial development* that is more widely used and accepted than Freud's psychosexual development model.

Karen Horney Born in Hamburg, Germany, in 1885, Horney was a female pioneer in psychoanalysis, a founding member and first female instructor at the Berlin Psychoanalytic Institute. In the 1920s and 1930s, she critically examined Freud's theories and their applicability for women's psychosocial development. In 1932, she moved to the United States, where she became involved with the New York Psychoanalytic Institute, from which she was fired as an instructor because of her critique of Freud in her 1939 book *New Ways in Psychoanalysis*. She then founded the American Institute of Psychoanalysis, which is still active today.

Object Relations Theorists Who Incorporated Drive Theory

Otto Kernberg (American School of Object Relations) Born in Vienna in 1928, educated in Chile, trained at the Menninger Clinic in Kansas, and based in New York, Kernberg integrated drive theory and object relations theory and focused his work on borderline personality disorder.

Melanie Klein (British School of Object Relations) Born in Vienna in 1882 and resettled in London in 1926, Klein developed a unique form of object relations therapy that incorporates both Freud's drive theory and object relations theory, and she is considered to be the most influential person in the field since Freud (Mitchell & Black, 1995). Unlike Freud, she worked directly with troubled children, a pioneer in child and play therapy (Klein, 1975).

Margaret Mahler (American School of Object Relations) Born in Vienna in 1897, Mahler was a Jewish physician and psychoanalyst who fled to New York in 1938 and became a consultant to the Children's Service of the New York State Psychiatric Institute. She developed a theory of separation and individuation that details the process of "psychological birth," by which an infant becomes psychologically separate from its caregivers in the first three years (Mahler, Pine, & Bergman, 1975).

Object Relations Theorists Who Did Not Use Drive Theory

William Ronald Dodds Fairbairn (British School of Object Relations) Born in Edinburgh in 1889, Fairbairn developed a "pure" object relations model—purely psychological—without biological drive elements. He "understood ego in terms of the ego striving for a relationship with an object, not merely seeking satisfaction" (St. Clair, 2000, p. 50).

Donald Winnicott (British School of Object Relations) An English pediatrician, Winnicott's "ideas have likely had more influence on the understanding of the common, significant issues met by psychoanalysts and psychotherapists in their everyday practice than anyone since Freud" (Bacal & Newman, 1990, p. 189). His concepts include the transitional object, good-enough mothering, true self, and false self.

Interpersonal

Henry Stack Sullivan Born in 1892 in New York, Sullivan was one of the first American analysts, his work representing a more optimistic view of human nature as well as an approach that better reflects American ways of life. Although he employs a type of drive

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theory, his approach emphasized a drive for relatedness as the primary drive rather than sex or aggression and is referred to as *interpersonal theory*, a distinct form of object relations analysis (Mitchell & Black, 1995). His work was among the first to consider the impact of culture and relationships in understanding mental illness. Considered almost heretical by some because he did not emphasize "depth" and the unconscious, he advocated analyzing verifiable observable data rather than the unconscious mind (Greenberg & Mitchell, 1983). His approach was seminal in the development of other approaches, including relational psychoanalysis and systemic family therapy (see Chapter 11).

Self Psychology

Heinz Kohut Born in 1913 in Vienna, Kohut received his MD at the University of Vienna in neurology and fled like other influential Jews in Austria in 1939. He settled in Chicago and became a prominent member of the Chicago Institute for Psychoanalysis, developing the psychoanalytic approach of self psychology, which he developed primarily with narcissistic patients for whom traditional analysis did not work. He rejected Freud's structure of the self—id, ego, and superego—and instead focused on a person's sense of self and self-worth.

Relational Model

Jay Greenberg Coauthored with Stephen Mitchell, Greenberg's *Object Relations in Psychoanalysis* (Greenberg & Mitchell, 1983) laid the foundation for relational theory. In this classic text, they divided psychoanalysis into two broad and what they believe to be theoretically irreconcilable approaches: Freud's drive model and the relational model, which includes psychologically oriented object relations approaches, self psychology, and the newly emerging relational psychoanalysis. Greenberg is a training and supervising analyst at the William Alanson White Institute of Psychiatry, Psychoanalysis, and Psychology and is a clinical associate professor of psychology at New York University.

Stephen Mitchell After completing his work with Greenberg, Mitchell spent the remainder of his career detailing a *relational* model for psychoanalysis that focuses on the internal structures that are developed from the individual's interpersonal experiences (Mitchell, 1988; Mitchell & Black, 1995).

Robert Stolorow Stolorow was a leader in bringing the intersubjectivity perspective to psychodynamic work, a perspective that challenges the prevailing belief in a discrete, individual mind and instead posits that emotional experience occurs within interconnected psychological systems or fields that are created by two or more people in a relationship (Stolorow et al., 1987).

Big Picture: Overview of Counseling Process

Listening, Interpretation, and Working Through

In general, current psychodynamic counseling involves three generic phases:

1. Listening with empathy to reduce defensiveness and increase willingness to hear interpretations
2. Interpretation to promote insight
3. Working through insight to promote new action

- *Listening and empathy:* The primary tool of psychoanalytic therapists is listening objectively to the client's story without offering advice, reassurance, validation, or confrontation. Empathy may be used to help the client open to nondefensively hearing the therapist's interpretation of unconscious dynamics.
- *Interpretation and promoting insight:* In the next phase, the focus is to encourage insights into personal and interpersonal dynamics, which the counselor promotes by offering interpretations to the client using various case conceptualization approaches; the form of case conceptualization is the most distinguishing feature between the various schools.

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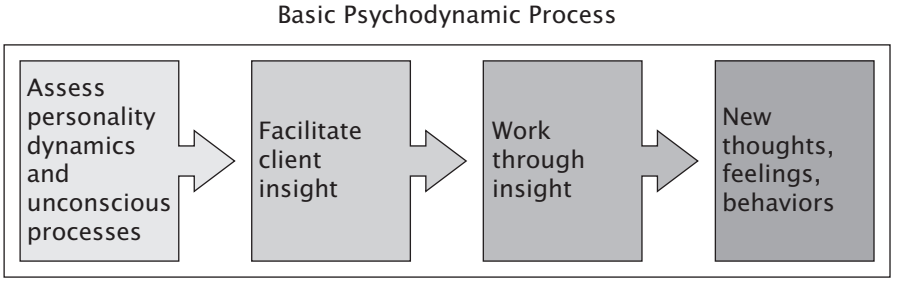
- *Working through:* Finally, *working through* refers to the process of repeatedly getting in touch with repressed strivings and defense responses so that the unconscious can be made conscious (St. Clair, 2000). The counselor facilitates this process by providing a realistic ego to help the client tolerate delay and anxiety as the client revisits, explores, and struggles to accept and understand drives, urges, and patterns that have been unrecognized. However, this is just the first step of the working-through process. Working through ultimately involves translating these insights into action. Understanding that you are projecting onto your partner feelings and expectations that really belong in your relationship with your mother is not too difficult; changing how you respond to your partner when you feel rejected and uncared for is more challenging.



Psychoanalysis

Psychoanalysis refers to an intensive approach designed to create significant and sustainable personality change (Abend, 2001; St. Clair, 2000). Analysts typically meet with patients (preferred term) three to five days per week for several years. Thus, a person doesn't casually stumble into analysis, nor should an analyst slyly lure someone into long-term analysis. It should be a process that is entered into with full knowledge and consent (McWilliams, 1999). The counseling process in psychoanalysis follows the above process, with the basic process of analysis–insight–working through–action frequently repeating at deeper and more profound levels. As analysis progresses, the process should—if all is going well—accelerate, with the client relying less and less on the analyst for insight and becoming more adept at working through new insights and translating them to real-world change. Psychoanalysis is typically an expensive endeavor for patients, and therefore it tends to attract wealthier and psychologically minded people who highly value insight.

Psychodynamic Counseling and Psychotherapy

In contrast to analysis, psychodynamic counseling and psychotherapy target specific symptoms or problems, such as depression or recovering from a divorce, with sessions typically occurring once per week and lasting several months to a couple of years, depending on client needs (Altman, 2008). More recently, brief forms of psychodynamic counseling have been developed to last 12 to 16 sessions. Again, the same basic process is employed, but the goals are narrower, creating a clearer criterion for termination (i.e., when the client is able to maintain prior level of work and social activity, counseling is done). As you can imagine, psychodynamic counseling is more common than psychoanalysis. Any of the schools in this chapter—drive theory, ego psychology, object relations, self psychology, and relational approaches—can be used in either psychoanalysis or psychodynamic counseling.

Making Connection: Counseling Relationship

Introduction to Psychoanalytic Relationships: One- and Two-Person Relationships

Each school of psychodynamic counseling has a differing approach to relationships, ranging from a highly distant blank-slate role of the drive theory analyst to a highly engaged, deeply human intersubjective approach. Mitchell (2000) differentiates these

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into two general types: *one-person* versus *two-person* psychology. In approaches that emphasize *one-person psychology*, the entire focus and process of analysis is on—you guessed it—one person, the client. Although historically the primary form of relationship in psychodynamic approaches, the one-person psychology relationship is increasingly rare and is typically used only in formal analysis that emphasizes drive theory and ego psychology (Marmor, 1997).

In *two-person psychology*, analysis includes—bet you can guess this—two people: counselor and client. In this approach, counselors are keenly aware of their impact on clients. First articulated by object relations and self psychology practitioners and developed most fully by relationally oriented practitioners, two-person psychology is increasingly used by the majority of psychodynamic practitioners. That said, it is perhaps best to think of these existing on a continuum, with newer forms of psychodynamic practice emphasizing the more relational two-person psychology, and more traditionally oriented and analytically focused counselors emphasizing one-person psychology.

Transference and Countertransference (see "The Juice" above) Neutrality and the Blank Slate (Drive Theory and Ego Psychology)

Freudian and ego psychology analysis typically maintain *neutrality* in relation to clients, to provide a blank slate on which clients can project unconscious material that the analyst can then use to promote insight. This stance, sometimes referred to as the *rule of abstinence*, requires that the analyst not gratify the client's instinctual demands, such as wanting more connection with the counselor or for the counselor to agree with the client on various topics. Kernberg (1997) explains, "The psychoanalyst, I believe, should behave as naturally as possible, without any self-revelation and without gratifying the patient's curiosity and transference demands, and acting, outside his specific technical function, within ordinary norms of social interaction" (p. 12).

This neutral stance is *not* used simply to frustrate clients but is considered essential to helping clients. Especially in formal analysis, the analyst keeps responses short, offers little new information to the conversation, is slow to reveal personal information or opinions (either verbally or nonverbally), and avoids discussing topics unrelated to the process at hand. By being more of a recipient, the analyst can carefully observe clients to study their internal and unconscious processes and, most important, *allow for transference*. For example, if a client harbors fears of not being smart enough, the client is likely to project these fears onto the analyst's cool interactions and assume that the analyst thinks that she is dumb or that her fears are silly. The less-than-chatty approach, when done well, is done from a place of empathy (albeit unexpressed) and a desire to help clients more quickly gain insight into relational patterns and use these insights to make meaningful life change.

Holding Environment (Object Relations)

Winnicott (1965) originally discussed *holding environment* as it relates to good-enough mothering (see Good-Enough Mothering and the True Self below) and refers to the nurturing environment provided by the mother that enables the child to move from an unintegrated state to having a structured, integrated self. A successful holding environment reduces overwhelming stimuli that the child cannot yet manage—thus requiring skillful empathy on the part of the mother/caregiver. By protecting the child against overwhelming events, the child avoids ego fragmentation and develops positive feelings about the self and sense of being real.

The concept of a holding environment is also used to refer to the counselor-client relationship in which the counselor provides a supportive, nurturing environment that enables the client to develop a structured, integrated self and a positive sense of self, which, in the case of many clients, did not happen as successfully in childhood as it could have (Brown, 1981). When applied to the counseling process, holding environment refers to providing structure, consistency, and routine to filter out overwhelming stimuli and enable the client to develop the ego strength to do the work of psychoanalysis. In this process, the structure of the counseling process takes care of ego maintenance functions so that the client has freed energy to work through and resolve conflicts and developmental crises.

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Empathy (Object Relations, Self Psychology, and Relational Theory)

Empathy—the ability to grasp another's internal reality—is required of all good counselors. However, the counselor's use and demonstration of empathy varies dramatically, depending on the counselor's theory. For example, traditional Freudian analysis relies heavily on empathy, but empathy is expressed not as a warm, "I-feel-your-pain" manner but rather through highly logical interpretive insight that requires empathy to ascertain. Within the psychodynamic circles, Kohut was the first strong advocate for supportive expressions of empathy in psychoanalysis and used it primarily when there was tension between the client and the analyst, to allow for corrective emotional experiences (Kohut, 1984). However, he was not the first to use it: "Although self psychology must not claim that it has provided psychoanalysis with a new kind of empathy, it can claim that I have supplied analysis with new theories which broaden and deepen the field of empathic perception" (Kohut, 1984, p. 175). Kohut described the practice of empathy as the analyst verbalizing to the client that he grasped what the client is feeling, demonstrating that the client has been understood. Thus, empathetic expression involves first grasping and then sharing aloud this understanding. The concept of empathy has been broadened to include empathizing with that which the client cannot tolerate in himself, projections, and other forms of dissociations from self (Kernberg, 1997).

Mirroring (Self Psychology)

A term from self psychology, *mirroring* refers to the counselor confirming the client's sense of self. Kohut believed that healthy adults "continue to need the mirroring of the self by selfobjects [persons experienced as part of self functioning and identity] throughout life" (St. Clair, 2000, p. 146). When met with indifference by someone with whom one is trying to connect, a person is left feeling helpless and empty and with a lowered sense of self-esteem. Thus, counselors provide mirroring for clients by confirming their worth, both verbally and nonverbally. This differs from empathy, which involves identifying and reflecting back the client's subjective reality, particularly an emotional state. In the case study at the end of this chapter, the counselor uses mirroring with Heidi, a 73-year-old retired banking executive whose family fled when the Nazis entered Austria while she was still an infant.

Relational Psychoanalysis and Intersubjectivity

Based on social constructionist theory (see Chapter 13), relational and intersubjective psychoanalysis approaches maintain that the analyst cannot be neutral but is an active agent in the dynamic interactions that occur in session (Stolorow et al., 1987). Greenberg (2001) identifies four assumptions that relational psychoanalysts use in understanding the counseling relationship; these are views that are not shared with any other psychodynamic school:

1. The analyst has a deep, personal influence on the client and has more influence than is typically acknowledged.
2. The impact of the analyst's behavior can never be understood while it is happening, if ever.
3. The analyst cannot adopt any posture, including neutrality or empathy, that guarantees a predictable atmosphere and relationship; instead, each relationship must be uniquely negotiated to suit both client and counselor.
4. The analyst is a subjective participant in the analysis process; objective neutrality is impossible.

In the relational psychoanalysis, the analyst's role is to provide useful ideas and explore their relational interactions to help clients reach their goals. Unlike other schools of psychoanalysis, they do not presume that they have a more accurate truth, understanding, or interpretation of the client's life than the client does. Relational psychoanalysts strive to create an intersubjective relationship with clients in which both the analyst and client mutually influence each other, co-creating interpretations and better understandings of self and other.

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Personal Analysis

From its inception and perhaps more than any other approach, psychoanalysis has required that analysts go through analysis themselves in order to be helpful to clients. In fact, a person's credibility as an analyst is often established by whom one sought for analysis. If a counselor has not deeply explored unconscious patterns, he or she will inevitably project these onto clients, act out on the basis of these unconscious patterns, and/or misinterpret elements from clients' lives. Thus, in order to "train" to be a psychodynamic counselor, one must first go through what is typically several years of analysis oneself. In fact, many would consider it *unethical* (scope of competence issue) to practice analysis and psychodynamic counseling without having experienced the process oneself.

The Viewing: Case Conceptualization

Introduction to Psychodynamic Case Conceptualization

You will quickly note that "The Viewing" section is far, far longer and more complex than "The Doing" section in this chapter. Should you want to curse me halfway through, just remember that would be a form of "projection" (see "Defense Mechanisms"): I am just the messenger here. What is important to note is that most of the work in psychodynamic counseling is in the viewing, the case conceptualization. Admittedly, case conceptualization doesn't get more intricate than this; the upside is that it is one of the most comprehensive approaches available. Increasingly, when conceptualizing, psychodynamic practitioners borrow freely from one school or another—drive theory, ego psychology, object relations, self psychology, relational theory, and even brief approaches—rather than stay rigidly wedded to one theory or another (McWilliams, 1999). This enables counselors to custom-tailor case conceptualizations for a single client; it also means that they must master many more concepts, which generally are not all used with every client. Hang tough for what is a case conceptualization half-marathon (13 areas for potential assessment).

Levels of Consciousness: Conscious, Preconscious, and Unconscious (Drive Theory)

Freud described three levels of consciousness: the conscious, the preconscious, and the unconscious, considered one of his earliest and most enduring contributions. The *conscious* mind includes sensations and experiences that the person is aware of, such as awareness that you are tired, hungry, and/or currently reading a long (hopefully not too boring) chapter on psychoanalysis. Freud believed the conscious mind comprised a small part of mental life. The *preconscious* holds memories and experiences that a person can easily retrieve at will, such as what you ate for dinner last night, lines from your favorite song, or elements of this chapter for your final exam. The *unconscious* holds memories, thoughts, and desires that the conscious mind cannot tolerate and is the source of innate drives; Freud believed this to be the largest level of consciousness and focused his work on making unconscious material conscious. Thus, most Freudian techniques are methods for making the unconscious conscious, such as dream analysis and free association. More recent practitioners distinguish the "present" unconscious from a person's childhood or "past" unconscious and often begin treatment by analyzing here-and-now unconscious meanings that are more "experience near" (related to client's current experiences) and easier for clients to relate to (Kernberg, 1997). Let's just hope that the contents of this chapter do not remain deeply hidden in your unconscious when it comes time to take the final exam.

Structures of the Self: Id, Ego, and Superego (Drive Theory)

The psychodynamic term *self* refers to the organization and integration of all psychic structures that make up the individual (St. Clair, 2000). An object relationship always takes place between the entire self and an object, not between elements of the self—such as ego or id—and an object. Freud conceptualized the self as having three structures that

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are used to conceptually understand and discuss psychodynamics but are not thought of as actual "things":

- *Das Es* ("The It"): Latinized for English speakers as *id* (the Latin term makes it sound more technical and mysterious than simply saying "the it"): Unorganized part of the personality that is motivated by instinctual drives; it inspires us to act according to the "pleasure principle." This part of the personality is almost—if not exclusively—unconscious. Infants are born with only id impulses and develop other personality structures in the first few years of life.
- *Das Ich* ("The I"): Latinized for English speakers as *ego*: The ego operates according to the "reality principle," striving to meet the needs of the id in socially appropriate ways. More a part of a person's conscious mind, the ego is the part of the personality that involves intellect, cognition, defense mechanisms, and other executive functions, and serves as a mediator between the id and the superego.
- *Das Über-Ich* (The Over/Above-I): Latinized for English speakers as *superego*: Always striving for perfection, the superego represents ego and social ideals and generally prohibits the id's drives and fantasies that are not socially acceptable.

Freudian analysts conceptualize client problems by examining how the ego manages the ongoing conflicts between the id's drives and the superego's prohibitions. In many cases, the ego "manages" these tensions using a defense mechanism.

Drive Theory (Drive Theory and Ego Psychology)

Freud conceptualized the human psyche as a type of machine: "he built his theory on a vision of man emphasizing the internal workings of a psychic apparatus fueled by the energy of instinctual drive" (Greenberg & Mitchell, 1983, p. viii). When energy within this system arises that cannot be "discharged," it must be managed and/or channeled in some fashion, such as denying or redirecting it. Freud identified the energy of the system as *libido*, a sexual energy, and after World War I added the *death drive*, the source of aggressive energy, as another form of energy that must be similarly managed. These energies are *instinctual drives* that are an inherent part of being human, experiences shared by all; however, when these drives are not properly acknowledged and managed, symptoms can develop. Freud's *psychosexual developmental model* (see below) described the development and maturation of libido energy. Although Freud did not develop a parallel model for the death drive, Melanie Klein, an object relations theorist, developed her ideas around the concept of the aggressive death drive (Altman, 2008). Other object relations theorists developed alternative drive theories that posited the drive for relationship; however, these relational drive theories are used primarily to describe the human need to seek relationship and generally do not include the mechanistic elements of Freud's drive theory.

Psychosexual Stages of Development and the Oedipal Complex (Drive Theory)

Based on drive theory and some of his most controversial ideas, Freud's *psychosexual stages of development* describe how the personality—id, ego, and superego—developed during the first five years of life. Freud believed that children experience general sexual/sensual gratification through various parts of the body until they reached adolescence, when sexuality pleasure becomes localized in the genitals. He acknowledged that this theory "may indeed sound strange enough … [but] we shall indeed be … richer by a motive for directing our attention to these most significant after-effects of infantile impressions which have hitherto been so grossly neglected" (Freud, 1963b, p. 13).

Contemporary practitioners are frequently divided into two general "camps": those who use drive theory and the psychosexual stages (Freudian drive theory analysis, ego psychologists, and some object relations practitioners) and those who believe drive theory and the psychosexual stages to be incompatible with object relations theory (self psychologists, interpersonal theorists, and the remaining object relations practitioners; Greenberg & Mitchell, 1983; Kernberg, 1997). There is also debate as to how literally versus metaphorically to interpret the psychosexual stages, with Americans tending to

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be more literal than their continental counterparts. Feminists have long critiqued Freud's psychosexual stages on numerous fronts, including the unabashed male bias that assigns a higher value to masculinity and uses masculinity as the standard by which females are understood (Friedan, 1963). Nonetheless, Freud's psychosexual stages provide a template for understanding how sexuality and aggressive drives may shape the personality and, more important, shape the development of the superego and morality.

Oral Stage: Dependency and Security (Birth to 18 Months) During this period, infants are dependent on their mothers to gratify their needs, which they do orally: sucking, biting, and spitting. If infants rely too heavily on the mother during this stage, they become *dependent* in adulthood. On the other hand, infants who too infrequently have their needs met may become *insecure* as an adult. In case formulation, psychodynamic counselors may refer to "orally dependent" personalities that have an exaggerated need to be nurtured.

Anal Stage: Control (18 months to 3 Years) During the anal stage, toddlers learn to control their sphincters, thus learning to manage the polarities of relaxation and rigidity. Children who become fixated in this stage may be *anally retentive*, developing an overly strong need to control urges and maintain control, or *anally expulsive*, unable to maintain control over instinctual urges.

Phallic Stage: Morality and Superego (3 to 6 Years) The most controversial of Freud's theories and a surefire way to add zest to any conversation that lacks enthusiasm, the phallic stage is marked by the Oedipus/Electra complexes, castration anxiety, and penis envy. Named after Sophocles' famous Greek tragedy, the *Oedipal complex* refers to what Freud believed to be a universal pattern in which boys directed their sensual impulses toward their mothers and had aggressive impulses toward their fathers; similarly, the *Electra complex* refers to girls who desire their fathers and want to eliminate their mothers. Children successfully resolve these libidinal instincts by developing a *superego* that enables them to identify with the same-sex parent and change from erotic to nonsexual love for the opposite-sex parent. *Castration anxiety* refers to a boy's fear that he may be castrated as punishment for masturbating, Oedipal urges, or other expressions of libidinal energy, all of which were strictly prohibited in Freud's era when boys were frequently warned that their penises would fall off if they played with them. On the other hand, girls may develop *penis envy*, wondering if they had done something wrong and already lost theirs. These theories developed from his early female patients reporting sexual advances by older men. Initially, Freud believed the reports to be what we now call sexual abuse, but later he believed that they must have been fantasies. As you might imagine, modern feminists as well as gay/lesbian advocates vociferously object to these theories, as they imply that homosexuality is a failure in development, that young children sexually desire their parents, and that sexual abuse can be blamed on children who "seduce" their parents.

Perhaps best understood in a more metaphoric sense, the important outcome of the phallic stage is the development of the superego and a sense of morality: "The superego embodies a successful identification with the parents' superego and gives permanent expression to their influence" (St. Clair, 2000, p. 26). Freud similarly emphasized the importance of the ultimate outcome as developing a conscious or superego so that one can successfully participate in society: "Whether one has killed one's father or has abstained from doing so is not really the decisive thing. One is bound to feel guilty in either case" (Freud, 1961, p. 89).

Latency Stage: Sexuality Latent (6 to 12 Years) In the latency period, libidinal energy is channeled to normal childhood activities, such as school, friendship, and hobbies; this is a period in which libidinal sexual conflicts are not typically present.

Genital Stage: Adult Sexuality (12 or More Years) In this stage, sexual energy is focused on members of the opposite sex. If issues were not appropriately resolved in earlier stages, they are likely to create difficulties and symptoms in adulthood.

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Symptoms as Intrapsychic Conflict: Primary and Secondary Gains

Presenting symptoms, such as a phobia, depression, or psychosomatic complaint, are viewed as expressions of inner or *intrapsychic conflict*, often a metaphor for emotions that cannot otherwise be consciously acknowledged and/or expressed (Luborsky et al., 2008). The analyst views these symptoms as clues to the client's underlying inner conflicts. The goal of therapy in such cases is to gain awareness and enable safe expression of these emotions. For example, a client who complains of chronic back pain may be feeling burdened in a relationship or at work, or a client who has a fear of heights may be afraid of realizing his full potential.

Primary gains and *secondary gains* of a particular symptom are also considered in assessment (McWilliams, 1999). Primary gains refer to the primary benefit of the symptom. For example, the primary gain of a teen's depression may be that the loss of energy and interest enables him to avoid an activity that causes distress in some way (e.g., he may feel that he is not good at sports, and being too depressed to go to practice allows him to get out of this). In addition, there are often *secondary gains*, which are benefits that are not immediately related but a natural consequence nonetheless. For example, the depression may get him attention from girls at school, released from normal chores, out of visits to extended family, or—whoops!—whatever he wants because a counselor takes his side against his parents. Thus, professionals need to be careful that they don't inadvertently create secondary gains in the name of being helpful, which requires careful thought, because what might be therapeutic for one client is a secondary gain for another.

Defense Mechanisms (Drive Theory, Ego Psychology, Object Relations, and Self Psychology)

Defense mechanisms are automatic responses to perceived psychological threats and are often activated on an unconscious level (Luborsky et al., 2008). When the ego is unable to reconcile tensions between the id and the superego and/or manage unacceptable drives, it may use one or more defense mechanisms to manage the seemingly irreconcilable conflict. When used periodically, defense mechanisms can be adaptive ways of coping with stress; when used regularly, they become quite problematic. Freud began identifying these early in his work, and later theorists have continued adding to the list. Following are some of the more common forms of defense mechanisms (see also Chapter 16 for additional discussion of defense mechanisms). In the case study at the end of this chapter, the client's long-term reliance on several defense mechanisms to suppress emotions resulted in chronic worry that has only gotten worse over the years; the counselor helps her bring these emotions into her consciousness so that she can more effectively deal with them.

Denial One of the first defenses identified by Freud, denial is the refusal to accept an external reality or fact because it is too threatening and may involve the reversal of facts (Luborsky et al., 2008). Denial is commonly seen in families with substance and alcohol abuse as well as people in dead-end jobs and relationships.

Introjection The earliest form of identification used by infants, introjection describes when one "takes in whole" behaviors, beliefs, and attitudes of another. In the case of infants, their earliest object relations are formed by introjections of their caregivers. Introjections can have positive or negative emotional valence. Initially, infants "split" these into two sets of memories, and in healthy development these become integrated (Kernberg, 1976). Adults who use the defense of introjection "swallow whole" the opinions, style, and characteristics of others in order to identify with them or gain their approval.

Splitting (Object Relations and Self Psychology) A defense that is of particular interest to object relations and self psychologists, splitting refers to the inability to see an individual as an integrated whole that has both positive and negative qualities (St. Clair, 2000). Splitting is normal for infants, but as they mature, infants are better able to understand that the mother who feeds them when they are hungry ("good" mother) is the same as the one who straps them into an uncomfortable car seat ("bad" mother). When an

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adult uses splitting as a defense mechanism, the person switches from seeing people as all-good or all-bad: idealizing and then villainizing. In some cases, they can rapidly alternate between an all-good or all-bad view of the same person, creating significant chaos in relationships. As you can imagine, this results in very difficult interpersonal relationships; my teen clients refer to them as the "drama queens and kings." Splitting is a defense that is commonly seen in borderline personality disorder.

Projection Projection refers to falsely attributing one's own unacceptable feelings, impulses, or wishes onto another, typically without being aware of what one is doing (e.g., seeing others as greedy but not recognizing this characteristic in oneself; Mitchell & Black, 1995). In clinical practice, this is often seen in the case where one partner thinks of cheating and then projects these intentions onto the faithful partner.

Projective Identification Similar to simple projection, projective identification involves falsely attributing to another one's own unacceptable feelings. However, in this case, "what is projected is not simply discrete impulses, but a part of the self—not just aggressive impulses, for example, but a bad self, now located in another" (Mitchell & Black, 1995, p. 101). Since what is projected is part of the self, there is a continued unconscious identification that maintains a typically strong and animated connection and control. Furthermore, in many cases the person's controlling behaviors often result in the other person acting in such a way as to confirm the projection, making it difficult to clarify who did what to whom first. The classic example of this is jealousy: a person is jealous of his partner's relationship with other men but claims that is because of her behavior. His jealousy causes her to be more secretive to avoid conflict, which further confirms his hypothesis about her, quickly creating a negative, downward spiral. Projective identification can also take the form of a radical activist against violence (pick one: animal, child, embryo, women, etc.) who projects aggressive impulses on others and then puts obsessive effort into promoting nonviolence, often using violent metaphors and sometimes violent means. Even when advocating noble causes, such a person tends to recklessly pursue the perceived evil in others to the point where their personal relationships, career, and well-being are harmed.

Repression A central concept in Freud's approach and considered one of the two basic defenses by Kernberg (along with splitting; 1976), repression describes the *unconscious process* that occurs when the superego seeks to *repress* the id's innate impulses and drives (St. Clair, 2000). In drive theory, repression is the cause of a wide range of neurotic symptoms, such as obsessions, compulsions, hallucinations, psychosomatic complaints, anxiety, and depression. Because it happens outside of awareness, repression is considered more pathological than *suppression*, in which the person consciously pushes the impulse out of mind.

Suppression Unlike repression, suppression is the *intentional* avoidance of difficult inner thoughts, feelings, and desires. When thoughtfully chosen, this defense can be very useful when facing difficult emotions over extended periods of time, such as grief, complicated loss, and so on.

Erickson's Psychosocial Stages of Development (Ego Psychology)

One of the most widely used developmental models, Erickson's (1994; Erickson & Erickson, 1998) eight-stage psychosocial model of development describes developmental crises that must be negotiated at eight significant points in life (see also Chapter 16). If these crises are not mastered, difficulties are encountered in subsequent stages. His stages closely parallel Freud's psychosexual stages initially but then extend across the life span.

Trust Versus Mistrust: Infant Stage Applicable to the first year or two of life, infants in this stage develop a healthy balance of trust and mistrust based on their experiences with early caregivers. A healthy balance of trust translates to a general sense of hope

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and safety in the world while simultaneously knowing when caution is warranted. Persons who have had traumatic childhoods or whose parents overly protected them often have confusion over when, where, and who to trust, resulting in a sense of being either unrealistically entitled or needlessly afraid.

Autonomy Versus Shame and Doubt: Toddler Stage During toddlerhood, children develop a sense of autonomy and influence in their lives while also learning the limits of their abilities. If caretakers are either neglectful or overly protective, children become overburdened with a sense of shame and may grow up to have lingering issues that manifest as extreme self-doubt or debilitating shame and/or shyness. Alternatively, if parents do not allow their children to experience shame and self-doubt, these children tend to become impulsive and inconsiderate of others.

Initiative Versus Guilt: Preschool and Kindergarten Age During preschool and kindergarten, children transition through a developmental stage in which they develop a sense of initiative and purpose tempered by guilt when their actions hurt others. Children who have either overly protective or neglectful parents may develop a strong sense of guilt and insecurity about making their own choices, leading to risk avoidance and inhibition. Alternatively, children who have an underdeveloped awareness of guilt and how their actions affect others become overly aggressive and even ruthless.

Industry Versus Inferiority: School Age In the early years in school, children learn new skills, developing a sense of competence from which they build their sense of self-worth; thus, the task at this stage is to engage in industrious activities to build confidence in their abilities. Children who are frequently criticized or compared to others and found to be lacking develop a pervasive sense of inferiority. Recent research also shows that overly praised children who are protected from experiencing failure and obstacles also develop a sense of inferiority because they are thwarted from developing a genuine sense of mastery (Seligman, 2002). Thus, contrary to their parents' intentions, children who are constantly sheltered from the feelings of losing a game, getting bad grades, being left out, and similar feelings of inferiority are actually likely to develop a lingering sense of inadequacy as they get older that can manifest as "underachieving" down the road. Alternatively, overly identifying with one's industriousness can result in obsessiveness in their activities.

Identity Versus Identity Confusion: Adolescence Few developmental stages are more fabled—or as well researched—as adolescence. Erickson saw this as a time of identity development when a person first begins to answer questions, such as who am I and how do I fit in? Developmentally, this is a time of exploring possible identities and social roles, which often takes the form of wild outfits, colorful hair, rebellious music, rotating social groups, and other ways to magnificently annoy one's parents. Teens who are not allowed to explore their identity or are made to feel guilty for not pursuing certain life paths may experience role confusion, failing to identify a clear or viable sense of identity. Alternatively, role confusion can also take the form of failing to adopt a viable social role and instead developing a reactive identity that is based on a rebellious need to "not be" what someone wants, often taking the form of drug use, a radical social group, gang membership, or high school dropout. In such cases, teens are not able to conceive of themselves as productive members of their family or society.

Intimacy Versus Isolation: Young Adulthood In recent generations, young adulthood has become much longer than in years prior because of more people seeking higher education and changing views of marriage and "settling down." During this time, a person establishes intimate relationships in their personal, social, and work lives, developing their own families and social network. People who struggle at this stage can become either overly focused on their relationships, possibly becoming sexually promiscuous, or overly identified with being in a relationship or becoming increasingly socially isolated.

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Generativity Versus Stagnation: Adulthood The developmental tasks of adulthood focus on feeling as though one meaningfully contributes to society and the succeeding generations and is often measured by whether one is satisfied with life accomplishments. A midlife crisis refers to feeling as though one's life is stagnant, off course, and/or in need of fixing, which some pursue by trying to make radical life changes—sometimes these help and at other times get a person even more off course. Often, the consequences of developmental deficiencies from prior stages come to a head during this time and can now be worked through and more readily addressed. Additionally, developmental issues at this stage can take the form of being overly involved and extended in one's social or work world or, alternatively, becoming cynical and disconnected.

Integrity Versus Despair: Late Adulthood The final developmental stage is an increasingly important one for counselors to understand as more elderly are receiving professional services. During this stage, a person balances a sense of integrity with a sense of despair as one looks back over one's life and faces the inevitability of death. Those who are able to face the end of life with a greater sense of integrity and wisdom are able to integrate the experiences of their lives to make meaning and accept what and who they have been. In contrast, others struggle to make peace with their lives and with life more generally and experience inconsolable sadness and loss or, alternatively, develop a false sense of self-importance that is conveyed as arrogance and self-righteousness.

Object Relations Theory

A term first coined by Freud and objectionable (no pun intended) to modern ears, *object* in psychodynamic theory is used to refer to the "object" of a person's desire, attention, or "drive" (think "object of my affection"; St. Clair, 2000). So, yes, it often refers to a person, most often one's mother. It derives from subject/object distinction in classic grammar: the subject (of the sentence) does something (verb) to an object. Objects can be *internal* (operating in one's internal world) or *external* (existing in the "real" world). Freudian drive theory analyzes how a person relates to the "objects" of his or her psychosexual and life/death drives. In contrast, object relations theory explores how a person relates to external and internal objects to understand personality dynamics. Object relations theorists believe that the personality results from the *internalization* and *introjection* of external interaction patterns with objects, namely, primary caregivers (Fairbairn, 1954; Kernberg, 1976; St. Clair, 2000). *The relationships with caregivers become the templates for all future relationships* and hence are carefully assessed and analyzed to understand problems later in life.

Object relation theorists are most concerned with how the infant internalizes relationships in the first three years of life and analyze how this affects adult personality development. Initially, "introjections [of caregivers] with positive valence and those with negative valence are thus kept complete apart, simply because they happen separately and because of the ego's incapacity to integrate introjections not activated by similar valences" (Kernberg, 1976, p. 35). The most critical task in the first three years then becomes to integrate "good" and "bad" objects into a coherent, realistic understanding of another and avoid the defense mechanism of *splitting* and *repression* (see preceding text). When a young child is abused or frustrated and lacks any control over the situation, a common coping strategy is to "split" the object into "good" and "bad" aspects and then internalize the "bad" aspect, making the external and uncontrollable object "good" and the self "bad." Thus, to emotionally survive, abused children may hate themselves and love their abusive caregivers, resulting in a pattern of continued victimization in adulthood. The focus of treatment in such cases is to identify, make conscious, and integrate these good and bad parts to create a more coherent identity, realistic expectations of others, and new relationship patterns.

Good-Enough Mothering and the True Self (Object Relations)

Good news for perfectionists, Winnicott's (1965) observations revealed that mothers who were generally (but not perfectly) able to respond to their infants' communication and

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needs while allowing them to move toward independence provided "good-enough" mothering, allowing the child to develop a *true self*. When relating from the true self, a person can spontaneously express needs and desires while maintaining a clear distinction between self and other. In contrast, if the mother is too cold and distant and/or too chaotic, good-enough mothering does not occur, and the child may develop a *false self* that is overly anxious to comply with others, feels "unreal," and struggles in relationships. Winnicott's goal in therapy was to help clients repair parenting damage and restore a sense of true self. Modern research on brain development provides support for Winnicott's theory by linking healthy brain development with the quality of parental interaction with infants (Siegel, 1999).

Stages of Separation and Individuation (Mahler's Object Relations)

Margaret Mahler described a *separation-individuation* process during the first three years of life during which time the infant develops an intrapsychic sense of self that gives the child a sense of being an independent entity. Thus, her theory describes how a person is "psychologically born." She described a three-phase developmental process (St. Clair, 2000):

Stage 1: Normal infant autism: During the first month, newborns are unable to differentiate their actions and that of their caretakers; the primary task is to maintain a homeostatic equilibrium outside the womb.

Stage 2: Normal symbiosis: During the second month of life, a psychological shell begins to form for the infant that encloses the symbiotic relationship of mother and child as a dual entity. From this point on, infants begin to be aware of the need-satisfying object (i.e., mother). Mahler believed that severely disturbed children regressed to this mental state of fusion. Good mothering encourages the child toward sensory awareness of the environment.

Stage 3: Separation and individuation: In the final phase, which begins at five months and continues until three years of age, the child both (a) individuates, developing intrapsychic autonomy, and (b) separates, creating psychological differentiation from the mother. This third stage has four subphases:

Subphase 1: Differentiation and body image: The child begins to physically distance slightly from the mother when practicing motor skills, often "checking back" to make sure the mother is still there.

Subphase 2: Practicing: Once infants begin to walk, they increasingly venture away with periodic returns for emotional connection. This is a period in which the child feels omnipotence and a peak in an idealized state of self.

Subphase 3: Rapprochement: During the second half of the second year, toddlers become more aware of physical separateness, their sense of omnipotence declines, and they reexperience separation anxiety. This phase is marked by inner conflicts, resulting in demands for closeness alternating with demands for autonomy.

Subphase 4: Emotional object constancy and individuality: Beginning in the third year of life, children begin to develop emotional object constancy, using an integrated inner image of the good and bad aspects of mother that provides comfort in her physical absence. This whole-object representation allows children to develop a unified self-image.

Narcissism and Selfobjects (Self Psychology)

Kohut's self psychology is a unique form of object relations that he developed from his work with persons diagnosed with narcissistic personality disorder (St. Clair, 2000). Freud implied that narcissistic people could not be treated because they could not form relationships with others. In contrast, Kohut (1977) conceptualized such persons as having narcissistic object relations, viewing objects (i.e., others) as if they were parts of the self and/or performing a crucial function for the self. Kohut reversed Freud's assumptions

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that drives preceded a sense of self: "In Kohut's theorizing it is the self that develops and is the motivational centre of the person. Evidence of the 'drives,' 'drivenness,' rage, or perversions are the manifestations of structural vulnerabilities, experiences of selfobject failures, a breakdown of the self. That was the direction in which Kohut led psychoanalytic exploration" (Lachmann, 1993, p. 227).

As conceptualized by Kohut, the selfobjects are those persons or objects that are experienced as part of the self or are used in service of the self to provide identity (Kohut, 1984; St. Clair, 2000). They are not whole objects but rather a series of unconscious patterns and themes. Young children develop selfobjects on the basis of two things: (a) the *idealized image of the parents* ("my parents are perfect") and (b) the *grandiose part of the self* ("I deserve to get what I want"). These two create a tension between what the child should do (what the parent would do: the idealized selfobject) and what the child wants to do (the grandiose self). The empathetic relationship between the parents and child helps the child develop a *cohesive self*. Nontraumatic failures of parental responsiveness—minor delays in responding to needs, such as a delay in getting a hot meal to a hungry child—actually serve to develop the nuclear self. In contrast, childhood traumas and deprivation prevent the healthy development of self; thus, "the grandiose self and idealized objects continue in an unaltered form and strive for the fulfillment of their archaic needs" (St. Clair, 2000, p. 144). In these circumstances, the "selfobject experiences of all the preceding stages of his life reverberate unconsciously" (Kohut, 1984, p. 50), and these become the focus of self psychology treatment.

Relational Matrix

Abandoning drive theory, relational psychoanalysts use the *relational matrix* to organize, frame, and interpret clinical information (Mitchell, 1988). This matrix includes the self, the object, and transactional patterns and redefines how the "mind" is defined: *"Mind has been redefined from a set of predetermined structures emerging from inside an individual organism to transactional patterns and internal structures derived from an interactive, interpersonal field"* (p. 17; emphasis in the original). According to relational theory, the "self" cannot be understood or even meaningfully experienced outside of interpersonal relationships. In fact, for relation theorists, "*all* meaning is generated in relation, and therefore nothing is innate in quite the same way as it is in the drive model" (p. 61).

The relational approach conceptualizes the individual embedded within a web of relationships called the *relational matrix* or *interactional field*, in which an individual connects with and differentiates from others. Rather than the individual, the basic unit of analysis is the interactional field, considering the *person-in-context* at all times, making it more applicable for diverse clients. Both intrapsychic and interpersonal dynamics are part of the field, and each affects the other. In the interactional field model, the self is experienced differently in each relationship, in each selfobject relation. Thus, the self is discontinuous, with different selves experienced in different relationships. For example, you may be confident with your best friend, insecure with a partner, and difficult to please with your parents.

Unconscious Organizing Principles and Culture

A particular form of relational theory, intersubjectivity theory draws on constructivist theory, self psychology, and relational analysis (Stolorow et al., 1987). Based on postmodern constructivist philosophy, intersubjectivity theory posits that "people experience the world through the lens of their particular organizing frameworks—unique unconscious principles or templates—that formed based on early relational experiences" (Leone, 2008, p. 83). These unconscious principles are not a distortion or projection but rather an inescapable lens that each person develops in order to interpret his or her experiences. One *cannot not* have these principles or templates; without them, a person cannot organize his or her experiences.

These unconscious organizing principles are shaped not only by early childhood relationships but also by culture. Culture by definition is a set of shared unconscious organizing principles (Rubalcava & Waldman, 2004; Waldman & Rubalcava, 2005). Each person within a given culture develops his or her own set of unconscious

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organizing principles based on early relationships as well as other diversity variables, such as gender, age, education, and so on. During every moment of one's life, these unconscious organizing principles are used to inform one's sense of self, emotions, and behaviors. For example, whether a person interprets a friend's pat on the back as kind, rude, or inappropriate depends on these unconscious templates. Thus, intersubjectivity theorists radically redefine transference as a normal process that involves the client using unconscious organizing principles to interpret the counselor's behavior; the client cannot avoid doing this, nor can the counselor avoid countertransference. Intersubjectivity theorists use the immediacy of the counseling relationship to explore these principles and revise them as necessary to address current problems and relationships. In the case study at the end of this chapter, the counselor explores Heidi's unconscious organizing principles about the importance of achievement in defining self that were shaped by her early traumas and family losses.

Targeting Change: Goal Setting

General Goals of Psychoanalysis

Having specific theories of health, psychodynamic approaches share similar long-term goals. These are general goals that define "mental health." They include the following:

- Decreased irrational impulses (early and middle phase)
- Increased ability to manage stress; decreased use of defense mechanisms (early and middle phase)
- Increased ego strength, self-esteem, and self-cohesion (middle and late phase)
- Increased insight followed by agency (middle and late phase)
- Increased emotional maturity and intelligence (middle and late phase)
- Decreased perfectionism (middle and late phase)
- Decreased internal conflict and personality integration (late phase)
- Increased ability to experience mature dependency and intimacy (late phase)

Irrational Impulses Often, the earliest goals in treatment involve decreasing irrational impulses that result in compulsive or obsessive behaviors, self-destructive behaviors, substance abuse, depressive thinking, inappropriate sexual impulses, and so on (Messer & Warren, 1995). These impulsive behaviors and obsessive thoughts are typically what cause many clients to seek treatment; thus, they are often highly motivated or at least somewhat eager to see a quick reduction in frequency. Goals can be written to target a simple decrease, especially initially (e.g., reduce binge eating to no more than once per week), or total elimination of the behavior (e.g., no episodes of binge eating to be sustained for two months).

Stress Management and Defenses Early goals also target decreasing a client's use of defense mechanisms and increasing the client's ability to manage stress without them. When writing goals, the specific defense mechanisms being targeted should be specific because most of us have a wide variety of favorites for use in different circumstances and relationships, each potentially requiring different interventions (e.g., denial, projection, introjection, passive aggression).

Ego Strength, Self-Esteem, and Self-Cohesion As the mediator between the id's pleasure-seeking impulses, the superego's moral injunctions, and reality, the ego needs to be strong to keep a healthy balance. "Having ego strength" means that a person does not deny difficult realities but rather finds ways to cope that integrate the conflicting needs of the id, superego, and external world (McWilliams, 1999). By definition, the person does not blindly follow the id's pleasure-seeking drives, the superego's strict rules and dictates, or reality's most recent limits. Instead, the ego proactively engages the tension created by these opposing forces and seeks to find reasonable ways to mediate the differences and meet the various demands and needs without denying any. For example, when struggling with reading a difficult chapter, a person with ego strength may honor the needs of the id

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to find something better to do, the superego's demands to work harder, and reality's demands to prepare for a quiz by taking small breaks, asking for help, and/or setting aside extra time to study (so, go ahead, and enjoy your break; we'll be right here waiting for you).

Insight Followed by Agency "After the insight: agency." If agency, action, and change follow insight, then it is meaningful counseling. Therapeutic insight should strike like lightning, making it hard to return to one's old ways afterward. If a client has only insight after insight after insight and nothing changes, then you need to work on the defense of intellectualization that is preventing the message from hitting home. Although Freud and many who came after him considered insight "curative," practitioners in more recent decades agree that if insight is not followed by change, then it is not enough (McWilliams, 1999). Furthermore, relational and more modern practitioners believe that insight is best arrived at collaboratively—counselor and client working together—rather than the traditional analyst *providing* the insight for the client.

Emotional Maturity and Intelligence Psychoanalytic practices help develop emotional maturity, which closely correlates to what Daniel Goleman (1995) recently called *emotional intelligence* (McWilliams, 1999). Emotional maturity or intelligence involves being aware of what one is feeling, understanding why one feels that way, and managing the emotions in a mature and intelligent way—rather than blindly reacting based on id-like impulses or rigid superego codes of morality. Recent neurological research supports the practice of finding words to express emotion because emotional memories stored in more primitive, nonlinguistic parts of the brain can be brought to the prefrontal cortex, where it can be explored, understood, and transformed with language and greater understanding.

Perfectionism Another desired outcome of psychoanalytic counseling is to reduce the punitive nature of the superego, which typically takes the form of perfectionism (Messer & Warren, 1995). When a person's superego dominates the personality, the person becomes obsessed with following socially imposed rules and definitions of success without balancing the person's personal needs and drives. Although initially perfectionism often has many benefits in the form of worldly success, over time this strategy ultimately results in numerous potential neuroses, such as eating disorders, depression, and anxiety.

Personality Change Psychodynamic counseling approaches are designed to change personality and character structures; that is always the long-term goal and arguably the most essential. Personality change is achieved by resolving internal and often unconscious conflicts, and this involves a process of better understanding the self. Although initially Freud believed that insight was curative, most analysts today believe that insight is not enough: insight must be demonstrated by meaningful change in behaviors, thoughts, and feelings (Abend, 2001). Additionally, one of the most notable changes is in interpersonal relationships: clients should be able to have more meaningful and less conflictual relationships with significant people in their lives.

Mature Dependency and Intimacy By working through infant and childhood dependency issues, psychoanalysis enables adults to develop a mature and healthy dependency on others and the capacity for intimacy (McWilliams, 1999; Messer & Warren, 1995). Mature dependency involves acknowledging the human need for community, selecting supportive partners and friends, being emotionally vulnerable, and experiencing emotional and physical intimacy while still maintaining a clear identity. The other person is not expected to be all-nurturing or the panacea to life's problems but instead is accepted as an integrated whole: both the good and the bad parts. Furthermore, through psychoanalysis, clients develop the capacity for adult intimacy, which involves psychological and sexual vulnerability.

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The Doing: Interventions

Interpretation and Working Through Resistance

The most basic technique, all psychoanalytic approaches use interpretation of unconscious material to facilitate client insight. Numerous possibilities exist for interpretation:

- Dreams, fantasies, and daydreams
- Symptoms
- Transference and countertransference
- Favorite metaphors and word choice
- "Freudian" *slips of the tongue* (accidentally misspoken words that reveal unconscious motivations)
- Jokes and asides

Depending on the analyst's style of case conceptualization and analysis, the analyst may interpret sexually repressed material (drive theory), defense mechanisms (ego psychology), early childhood events (object relations), or selfobject conflicts (self psychology).

Like most things in life, the key to successful interpretation is timing! If the client is not ready, be prepared for *resistance*. In this case, the client is not ready to bring unconscious material to conscious awareness. In most cases, the closer the material is to preconsciousness, the more ready the client is for interpretation. For example, if the analyst has not felt that the client was ready to hear an interpretation that she is angry at her partner, but then the client reports that she was "shaken" by a dream in which she was yelling at a character who represents her husband, the analyst may use this moment to present the interpretation.

Although initially interpretation was used to promote cognitive insight, increasingly analysts from all schools of psychoanalysis also attend to clients' affective experience in making and assessing the effectiveness of interpretation: "in the clinical situation the dominance of affective investment has come to be accepted almost universally as the most appropriate point for analytic intervention" (Kernberg, 1997, p. 8). The "affective investment" does not simply refer to the most readily visible emotions; rather, it refers to a holistic analysis of where emotional energy is invested across the entire range of conscious and unconscious processes, including transference, infantile material, countertransference, and so on.

Steps to Providing Effective Interpretation

1. *Begin with case conceptualization:* Interpretation should not be made willy-nilly, off-the-cuff, or as the spirit moves. Instead, as a first step, the counselor needs to develop a well-crafted case conceptualization that thoughtfully reveals where the client invests most emotional energy (see "The Viewing" section for numerous options).
2. *Wait for the "moment":* Once you have a clear sense of the client's dynamics and issues, don't rush into the next session ready to proclaim your insightful truth. In fact, it is hard to prepare a well-crafted interpretation because, to be effective, most need to be presented when the client is ready to hear it, which is often after relating a new, often painful, difficult, or challenging event. In the struggle to understand what has just happened, most clients will then be more open to hearing an alternative perspective. The key is that when clients are still in the thralls of emotional upheaval, they are more likely to resist interpretation. So there is a sweet spot—somewhere between emotional turmoil and getting over it (by getting the defenses back on line), where clients pause to wonder, reflect, and ask why—that's the moment they are ready. Trust me, with time, you get better at finding this moment—it's generally obvious when you miss it.
3. *Work from the present to past:* In most cases—and certainly no single set of steps will work for all forms of interpretation—begin by describing dynamics in the present issue (e.g., what just happened in session, what happened at work, between counselor and client, or whatever is most upsetting)—and then make links to the past (e.g., relationship with mother, father, past abuse; Kernberg, 1997).

(*continued*)

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4. *Assess client response:* Finally, you need to assess how clients respond to the interpretation. Do they resist: "I don't think that is what is happening at all"? Or do they agree: "Wow. I never thought of it before, but I think you are right"? Or do they fall somewhere in between: "I don't know. Some of that might be true"? Different schools and individual practitioners have different approaches to responding to each type of response. New counselors are probably safest using a more collaborative, relational approach to work with the client's reality to reinterpret the interpretation in such a way that it not only "makes sense" in the client's subjective world but also translates to changes in action, feelings, and thoughts in their everyday life.

Try It Yourself

Either with a partner or on paper, identify a time when you used a specific defense mechanism. Use these steps for interpretation to develop an interpretation of what was happening in the situation. Bonus points for identifying denial and repression in yourself: typically we need the generous and hopefully gentle help of others for these!

Empathy: Understanding-Explaining Sequence

Kohut (1984) describes an *understanding-explaining sequence* to both solidify the counseling relationship and provide meaningful interpretation. Most often, these two are presented together in a single utterance by the counselor. However, he emphasizes that in some cases, especially with people who have been severely traumatized, this phase may remain the only phase for a very long time.

Empathetic Understanding-Explaining Sequence

This process involved two phases: understanding and explaining.

1. *Understanding:* The understanding phase was an expression of empathy: "I can understand how my being late must have been upsetting for you."
2. *Explanation:* The second phase, explaining, provides some form of interpretation that helps the client understand the source of the emotion: "We all care about how those around us see us and treat us, especially those who are important to us, much like our parents were to us years ago. Given your mother's unpredictability and your father's disinterest in you, my actions must have been especially upsetting."

Kohut used these two together to express a therapeutic expression of empathy that provides a corrective emotional experience and helps clients develop a more cohesive sense of self.

Kohut (1977) cautioned practitioners to look for evidence that a particular empathetic interpretation was correct. He states, "We also know that there is one attitude that, after it has become an integral part of our clinical stance, provides us with an important safeguard against errors arising in consequence of our instinctive commitment to established patterns of thought: our resolve not to be swept away by the comfortable certainty of the 'Aha-experience' of intuited knowledge but to keep our mind open and to continue our *trial empathy* in order to collect as many alternatives as possible" (Kohut, 1977, p. 168). Kohut believed that only a gradual change in symptoms and behavior patterns provide evidence that one's empathetic interpretations are correct. In the case study at the end of this chapter, the counselor uses the understanding-explaining sequence to help Heidi understand why she chose to pursue a career rather than a family and why she has had difficulty maintaining intimate relationships.

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Free Association

Developed by Freud, free association involves asking a client to "just say what comes to mind" on a given topic, such as "your mother," allowing unconscious material to arise. The client may describe recent events, memories, feelings, fantasies, bodily sensations, or any other material. Analysts may have clients lay on a couch rather than sit in a chair to encourage a more relaxed and free-flowing thought process to encourage unconscious thoughts to emerge. The analyst listens carefully for unusual connections, idiosyncratic logic, slips of the tongue, and efforts to edit or hold back. After this process, the analyst may provide interpretations to help promote insight into the client's process.

Dream Interpretation

"Dreams in general can be interpreted, and that after the work of interpretation has been completed they can be replaced by perfectly correctly constructed thoughts which find a recognizable position in the texture of the mind" (Freud, 1963a, p. 29).

Freud's approach to dream interpretation was revolutionary in his time, a period when scientists viewed dreams as a "somatic expression." In contradiction to the medical establishment, he proclaimed, "I must insist that the dream actually has significance, and that a scientific procedure in dream interpretation is possible" (Freud, 1974b, p. 83). Dubbed by Freud "the royal road to the unconscious," dream interpretation has been a key intervention since the beginning of psychoanalysis (Luborsky et al., 2008). In the tradition of Freud, the dreamer—not the analyst—is the key to symbolic meaning of the dreams; there are no predetermined meanings: "sometimes a cigar is just a cigar!" The dreamer's associations with symbols in the dream provide clues to underlying unconscious meaning of the dream. In dream analysis, dreams have two layers of meaning: the *manifest content* is the literal content of the dream, and the *latent content* is the underlying, unconscious material that must be interpreted to be accessed.

Intersubjective Responding

Relational psychodynamic counselors rely on the counseling relationship itself to create opportunities for clients to gain insight and make change, referred to as *intersubjective responding*. Using a postmodern approach, they do not necessarily relate every experience in the counseling relationship to childhood experiences but instead stay focused on the present relationship and the client's interpretations of it, which may be related to culture, gender, economic status, or education as well as to childhood experiences. For example, if a client comments that she is frustrated because she does not feel like the counselor is telling her what he really thinks, the counselor will approach this comment from a nondefensive and nonassuming position, curiously exploring her perception, the expectations behind it, and their antecedents, which may be related to numerous factors, including childhood relationships.

Putting It All Together: Psychodynamic Case Conceptualization and Treatment Plan Templates

Theory-Specific Case Conceptualization: Psychodynamic

Use the prompts below to develop a theory-specific case conceptualization; the case study at the end of the chapter provides an example.

- *Levels of Consciousness:* Describe salient dynamics of conscious versus unconscious processes.
- *Structures of the Self:* Describe the functioning and relationship between the client's ego, superego, and id.
- *Drive Theory:* Describe dynamics related to libidinal energy.
- *Secondary Gains:* Describe possible secondary gains related to client symptoms.

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- *Defense Mechanisms:* Describe three to four of the client's most frequently used defense mechanisms, which may include:
  - Acting out
  - Denial
  - Displacement
  - Help-rejecting complaining
  - Humor
  - Passive aggression
  - Projection
  - Projective identification
  - Rationalization
  - Reaction formation
  - Repression
  - Splitting
  - Sublimation
  - Suppression
- *Erickson's Psychosocial Stages of Development:* Describe salient issues at development at each stage up to the current stage:
  - Trust versus mistrust (infant stage)
  - Autonomy versus shame and doubt (toddler stage)
  - Initiative versus guilt (preschool age)
  - Industry versus inferiority (school age)
  - Identity versus identity confusion (adolescence)
  - Intimacy versus isolation (young adulthood)
  - Generativity versus stagnation (adulthood)
  - Integrity versus despair (late adulthood)
- *Object Relations Theory/True Self:* Describe attachment (secure, anxious, avoidant, or anxious-avoidant), general quality of relationship, and any attachment traumas with:
  - Early caregivers, in past and present
  - Current intimate relationships (partners, children, close friends)
- *Relational Matrix:* Describe the web of relationships and contexts through which the client understands self and world. Include intra- and interpersonal dynamics.
- *Unconscious Organizing Principles and Culture:* Describe unconscious organizing principles, highlighting those derived from racial, ethnic, gender, social class, sexual identity, ability, and other cultural dynamics.

Treatment Plan Template: Psychodynamic

Use this treatment plan template for developing a plan for clients with depressive, anxious, or compulsive types of presenting problems. Depending on the specific client, presenting problem, and clinical context, the goals and interventions in this template may need to be modified only slightly or significantly; you are encouraged to significantly revise the plan as needed. For the plan to be useful, goals and techniques should be written to target specific beliefs, behaviors, and emotions that the client is experiencing. The more specific, the more useful it will be to you.

Treatment Plan

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity considerations:* [Describe how you will specifically adapt your approach to be sensitive to client diversity when developing the counseling relationship; this may include respecting cultured and gendered norms for emotional expression.]

(*continued*)

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Relationship-building approach:

a. Use **empathy and mirroring** to provide a supportive, holding environment for client.

2. *Assess individual, systemic, and broader cultural dynamics. Diversity considerations:* [Describe how you will specifically adjust assessment based on cultural, socioeconomic, sexual orientation, gender, and other relevant norms.]
Assessment strategies:
   a. Analyze **unconscious conflict** underlying symptoms and role of **defense** mechanisms in managing them.
   b. Analyze **object relations and selfobjects** patterns, including expressions in current relationships and historical development during infancy.
   c. Assess **relational matrix** and culturally defined unconscious organizing principles that shape the client's worldview.

Initial Phase Client Goal

1. *Decrease* emotional reactivity to perceived **threats to self** to reduce [specific crisis symptoms].
Interventions:
   a. Provide **empathy** using **understanding-explaining** sequence to reduce client's inaccurate perceptions of external threat to self.
   b. Interpretation to reduce need to use reactive **defense mechanisms** in response to incorrectly perceived threats.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity considerations:* [Describe how you will remain sensitive to relationship and conflict management patterns that may be related to gender, cultural, socioeconomic status, family dynamics, and so on.]
Assessment Intervention:
   a. Monitor and work through **transference and countertransference**.

Working Phase Client Goals

1. *Decrease* use of [specify **defense mechanism**] to protect self from [specify perceived threat] to reduce [specific symptom: depression, anxiety, etc.].
Interventions:
   a. **Interpretation** of role of **defense mechanism** and how it developed in early childhood experiences and is being inappropriately used currently.
   b. Analysis of transference in session when defenses are used in relationship to counselor.

2. *Increase* ego **strength** and **self-cohesion** to reduce [specific symptom: depression, anxiety, etc.].
Interventions:
   a. **Mirroring** to confirm client's sense of worth and value.
   b. **Empathy** using the **understanding-explaining sequence** to increase client's sense of cohesion.
   c. **Dream interpretation** and **free association** to bring sources of inner conflict to conscious awareness.

3. *Increase* sense of personal agency informed by emotional intelligence to reduce [specific symptom: depression, anxiety, etc.].
Interventions:
   a. **Intersubjective responding** to increase client's awareness of self in sessions versus various emotional-relational contexts.
   b. **Working through resistance** to translating insight into action.

(*continued*)

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Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity considerations: [Describe how you will access resources in the communities of which they are a part to support them after treatment ends.]*
   Intervention:
   a. Analyzing **transference** and abandonment issues as impending termination approaches.

Closing Client Goals

1. *Decrease* internal conflict while increasing **personality integration** to reduce potential for relapse in [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. **Dream analysis, free association, and analysis of transference** to identify internal conflicts generally and those related to ending treatment specifically.
   b. Enable client to identify, consciously contain, and successfully manage internal conflicts to allow for fuller personality integration.
2. *Increase* ability to experience **mature dependency** and intimacy to reduce potential for relapse in [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. Analyze **transference and work through resistance** to intimacy in in-session and out-of-session relationships.
   b. **Intersubjective responding** to critically examine the unconscious organizing principles the client uses to relate to others.

Research and the Evidence Base

Although often having a reputation for little research support, psychodynamic counseling has a respectable and growing evidence base (Leichsenring, 2009; Shedler, 2010). The best and most rigorously researched psychodynamic approaches are the brief psychodynamic methods, many of which are recognized as evidence-based approaches by the U.S. National Institutes of Health (Luborsky et al., 2008; Weissman, Markowitz, & Klerman, 2000, 2007). The strongest support for the effectiveness of general psychodynamic counseling comes from large-scale studies comparing psychodynamic to other approaches such as cognitive-behavioral and humanistic, as was recently done in the United Kingdom, indicating no significant difference in outcome between theories (Stiles, Barkham, Mellor-Clark, & Connell, 2008). More recent studies show a trend for sustained gains and even *increasing* gains after counseling has ended (Abbass, Hancock, Henderson, & Kisely, 2006; Leichsenring, 2009). In addition, there is support for specific psychodynamic concepts. For example, using the Core Conflictual Relationship Theme, Luborsky and associates (Luborsky et al., 2008; Luborsky & Crits-Christoph, 1998, Luborksy & Luborksy, 2006) have researched and found evidence that supports the psychoanalytic concept of transference. Additional research is needed to compare the different models or schools of psychodynamic theory to determine if they vary in effectiveness generally or for specific issues (Leichsenring, 2009). Finally, newer areas of research in psychodynamic counseling focus on the neurological and physiological correlates of psychodynamic processes and inform new ways of conceptualizing unconscious process and attachment (Marci & Riess, 2009; Roffman, & Gerber, 2009).

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Evidence-Based Treatment: Brief Psychodynamic Counseling

In a Nutshell: The Least You Need to Know

Several "brief, psychodynamic" approaches have been developed and validated through research (Book, 1998; Messer & Warren, 1995). These approaches use many of the same case conceptualization skills as traditional psychodynamic approaches; however, they differ in the quality of the counseling relationship, the specificity of the goals, and the directiveness of the interventions. These "brief" approaches may require from 12 to 50 sessions but typically end after 20. Similar to other psychodynamic approaches, they believe that early childhood relationships significantly affect problems later in life and that defense mechanisms should be targeted in treatment. Thus, most brief psychodynamic approaches aim to strengthen the ego so that it can better manage problem impulses and resolve inner conflicts. The counselor is more active in these approaches, quickly identifying core dynamics that are targeted for intervention; the counselor-client relationship is used as a learning forum for *corrective emotional experiences*, in which the counselor's response helps correct old traumas.

Big Picture: Overview of Counseling Process

Sifneos (1979) identifies five phases of brief psychodynamic counseling and psychotherapies:

1. *Client-counseling encounter:* The client and counselor develop a working rapport and mutually agree on a focus of treatment. During this time, the counselor develops a case conceptualization of the client's dynamics, focusing on those that are related to the identified problem.
2. *Early treatment:* The counselor confronts idealistic, positive transference and helps the client distinguish wishful thinking from realistic expectations of the counselor and the counseling process.
3. *Height of treatment:* During this working phase, the past is explored to better understand current problems and transference issues that arise in session; clients are encouraged to use new ways of relating both in and out of session.
4. *Evidence of change:* Clients begin to apply what they learn in session to everyday life.
5. *Termination:* Once goals have been reached, counselors help them move toward termination rather than look for new goals. Careful attention is paid to issues of loss and separation as treatment ends.

Making Connection: Counseling Relationship

Corrective Emotional Experience

Rather than using transference and countertransference to promote insight into early childhood relationships, brief psychodynamic counselors use these immediate in-session interactions to promote *corrective emotional experiences*. Corrective emotional experiences involve using the counseling relationship to work through old childhood traumas and relational patterns (Mallinckrodt, 2010). For example, if a client perceives the counselor's professional mannerism as also implying disapproval, the counselor can use this opportunity to clarify that the professional boundaries are just that—professional boundaries—and do not imply any judgment or valuing of the client as a person, as may have been the case with the client's father or mother. When this is done with sincerity and without reactivity on the part of the counselor, this can be a profound healing experience for the client.

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Specific Brief Psychodynamic Approaches

Interpersonal Psychotherapy

Originally developed for treating depression, *interpersonal psychotherapy* has been used with couples, older adults, bipolar disorder, eating disorders, anxiety disorders, and borderline personality disorder (Weissman, Markowitz, & Klerman, 2000, 2007). In one of the largest mental health studies conducted in the United States, interpersonal psychotherapy was compared with cognitive therapy and antidepressant medication and found to be as effective (Krupnick, Elkin, Collins, Simmens, Sotsky, et al., 1994); thus, it has a well-respected evidence base. The approach is based on the assumption that stressful interpersonal experiences in adulthood trigger childhood attachment issues, resulting in depression or similar disorder. The approach focuses on building strong interpersonal relationships to reduce the likelihood of relapse.

Treatment is time-limited and focuses on the following four areas:

1. Interpersonal deficits (i.e., lack of skills or knowledge)
2. Role expectations and conflicts (i.e., creating realistic expectations)
3. Role transitions (i.e., redefining relationships based on developmental and contextual needs)
4. Grief issues (i.e., dealing with past and current relational loss)

Interpersonal psychotherapy has three phases:

Phase 1: Initial sessions: Focuses on identifying one or two concerns from the four areas listed above. The counseling process and diagnosis are explained so that the client fully understands the process and how it will help.

Phase 2: Intermediate phase: During this working phase, the counselor actively helps the client address the targeted problems using a wide range of interventions that include psychoeducation, interpretation of patterns, advice giving, insight-stimulating questions, and behavior change techniques.

Phase 3: Termination: Termination requires two to four sessions to help the client develop confidence that he or she can handle future problems using the skills that he or she has learned.

Core Conflictual Relationship Theme Method

Luborsky and colleagues (Luborsky & Crits-Christoph, 1998; Luborsky & Luborsky, 2006; Luborsky et al., 2008) have developed the Core Conflictual Relationship Theme method to operationalize transference in their brief, psychodynamic method. The method involves analyzing all accounts clients share about their interactions with others to identify core relationship themes that create conflict and problems. Counselors do this by analyzing three elements in each encounter reported by the client:

- W: The client's wish (W), either stated or implied (e.g., wanting to be loved, appreciated, acknowledged)
- RO: The response of others (RO), either real or imagined (e.g., rejection, disapproval, criticism, ignoring)
- RS: The response of self (RS) (e.g., anger, sadness, withdrawal, attacking other, blaming self, feeling trapped).

The counselor tracks these three elements in each problem encounter described by the client and helps the client to gain insight into these patterns and to change their responses. Research shows that clients' wishes generally remain the same, but their responses and those of others change.

Time-Limited, Dynamic Psychotherapy

Designed for persons diagnosed with personality disorders, time-limited dynamic psychotherapy uses the counseling relationship to encourage corrective emotional experiences (Levenson, 2003). Clients interact with counselors the same way they do with others in their lives. Counselors using a time-limited, dynamic approach use their responses within

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the counseling relationship to provide new experiences for clients that enable them to change how they interact with others outside of session. The counselor has a positive, supportive approach that provides clients safety in exploring these long-standing relational patterns. Initially, counselors begin by identifying present relationship patterns but then move toward exploring the early origins of these patterns. Counselors can help clients see how these patterns may have been adaptive earlier in life but no longer serve their purpose.

Tapestry Weaving: Working with Diverse Populations

Cultural and Ethnic Diversity

As traditionally practiced, psychoanalysis is generally considered not readily adaptable to other cultures (Luborsky et al., 2008; Green, 2004) or sexual minorities (Glassgold, & Iasenza, 2004) and has long been critiqued even from within the field as biased against women (Horney, 1939). Virtually all of the research on the approach has been exclusively with white clients (Watkins, 2012). However, more recently developed relational approaches enable psychodynamic practitioners to use a contextually sensitive approach that carefully incorporates the client's unique interpersonal context into the counseling process (Altman, 2008; Waldman & Rubalcava, 2005). Specifically, relational and intersubjectivity approaches recognize that both counselor and client "make sense of the other's affect, behavior, and expression in terms of their own unconscious cultural organizing principles"; "these dynamics are considered when assessing the intersubjective field" (Rubalcava & Waldman, 2004, p. 138). Additionally, some practitioners such as Fred Pine (1990) have adapted psychoanalytic work to be more "supportive" when working with poor clients and clients with limited educational backgrounds. Pine uses "ego building" interventions, such as naming feelings and alerting clients before offering a potentially difficult-to-hear interpretation.

Latinos/Latinas Gelman (2004) conducted a grounded theory study to identify how Latino clinicians successfully adapted psychodynamic therapy with Latino clients. The counselors in his study reported that they modified the following elements to successfully work with Latinos using psychodynamic theory:

- *Counseling Relationship and Personalismo:* In Latino culture, warmth, respect, and cordiality are part of relating to others, a quality referred to as *personalismo*. This sense of personal connection was furthered by speaking the same language and sharing a common culture. Because of this change to the more typically reserved psychodynamic relationships, the clinicians noted that they felt there was a greater risk of overidentification with clients. Thus, greater self-awareness on the part of the counselor was required to attend to transference and countertransference dynamics.
- *Individuality and Individually Tailored:* The counseling process was individually tailored to each client, given the great heterogeneity of Latino cultures as well as the impact of socioeconomic status and acculturation.
- *Flexibility in Approach:* Similarly, clinicians reported using a more flexible psychodynamic approach, such as more allowable phone contact between sessions.
- *Address External Realities:* External realities, including psychosocial pressures, are included in the analytic process. Concrete problems are addressed within the psychodynamic process as part of the work.
- *Self-Disclosure:* Latino clinicians reported using more self-disclosure with Latino clients because it is culturally expected.
- *Gift Giving:* Because gift giving is an important part of their culture, counselors were more likely to accept culturally appropriate gifts when working with Latino clients.
- *Physical Contact:* Clinicians also reported a willingness to engage in reasonable and appropriate physical contact with Latino clients, including handshaking, backpatting, and reduced interpersonal space. They described carefully assessing the potential meaning of such contact with each individual client.

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- *Activity and Direction:* Clinicians also reported being more active and directive, especially in terms of helping clients access resources.
- *Language as a Therapeutic Technique:* Clinicians report using language differently with Latino clients than non-Latino clients. When counseling was done in Spanish, the shift from a formal "you" (usted) to informal (tú) clearly signaled an increase in comfort and trust. Additionally, clinicians believed that speaking in one's native language accesses the psyche in a way that a second language cannot; thus, slipping into one's native language was seen as accessing more direct experience and emotions. Preference for using the second language was viewed as having several potential purposes and meanings: distancing from experience, distancing in the therapeutic relationship, demonstration of assimilation, or preference for an acculturated identity. Finally, language was used to modulate affect: with switching to the native language increasing affectivity and switching to the secondary language a means to reduce emotional charge.

East Asian Americans As many consider psychodynamic therapy ineffective with Asian clients, Yi (1995) proposes several modifications to traditional psychodynamic concepts using subjectivity theory (Stolorow, Brandschaft, & Atwood, 1987).

- *Self-Object Relations:* As early mother-infant relations are believed to be the foundation of self-object relations, it is important to recognize cultural differences that establish these patterns. In Asian cultures mothers are more likely to positively mirror interdependence and respect for others rather than individuation, which is valued more in the West.
- *Confucian Self:* Given the profound influence of the highly structured and hierarchical Confucian value system, East Asians internalize similar hierarchical representations of self and other, with clearly defined roles. Unlike common Western conceptualizations of hierarchy, Confucian hierarchy implies mutual and reciprocal duties and responsibilities to the other—not unidirectional power.
- *Transference Considerations:* In Asian cultures, relating to authority involves a benign positive idealization of the authority figure's power and wisdom and an expectation of benevolent guidance and protection. This respect is often expressed by taking a receptive, listening stance. This traditional Asian approach to relating to authority figures, such as doctors and other professionals, must not be misinterpreted as some form of regression or passive dependency. Instead, psychodynamic counselors need to carefully consider the client's level of acculturation, assess the client within cultural norms, and co-create an appropriate counseling relationship.
- *Empathic-Introspective Approach:* Yi strongly supports using an empathic-introspective approach with Asian clients, empathically understanding the clients from within their subjective world and using personal introspection on the part of the counselor to examine how his/her own personal subjective organizing principles are affecting the counseling process and interpretations of the clients. Counselors must continually examine their own assumptions and beliefs that are culturally bound, in order to more accurately make sense of the client's experiential world.

Sexual Identity Diversity

Freud is known for conflicting views and statements about homosexuality. He was a strong advocate for not criminalizing same-sex attraction and for proposing that everyone is capable of same-sex attraction but that most repress homoerotic thoughts and feelings (Rubenstein, 2003). However, his theory of psychosexual development identifies heterosexuality as the "natural outcome" of healthy development, pathologizing of homosexuality as an "arrest in development" (Izzard, 2000, p. 107). Over the years, his views have had a significant impact on the field's views of homosexuality. In the 1940s, his followers took a more clearly pathologizing stance on same-sex attraction, citing his theories (Rubenstein, 2003). More recently, gay affirmative analysts also cite his work

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to support a nonpathologizing approach to working with same-sex attraction (Izzard, 2000; Rubenstein, 2003).

In recent decades, influenced by feminists and postmodernists, most psychodynamic counselors have assumed a more contemporary view of same-sex attraction that is nonpathologizing (Cornett, 1993; Izzard, 2000). Much of the literature has focused on changing the personal attitudes and practices of clinicians, with relatively little focusing on reconceptualizing theory (Izzard, 2000). That said, two of the more frequently discussed issues in psychodynamic literature related to conceptualizing psychoanalysis with gay and lesbian clients are: internalized homophobia and the issue of the neutral therapeutic stance.

Internalized Homophobia: Shame and Self-Hatred: Psychodynamic analysis can help clinicians understand the process of internalized homophobia in gay, lesbian, and bisexual individuals (Izzard, 2000). Through the processes of identification and introjection, virtually all persons—gay or straight—in a heterosexist society develop homophobia. For those who are gay, this then becomes a source of self-hatred and shame. The lack of mirroring of their experience intensifies the sense of social stigma and isolation. The psychoanalytic process can be used to help clients work through the internalized homophobia and develop greater self-acceptance. As part of this acceptance process, clinicians also need to allow space for gay and lesbian clients to discuss the "shadow side" of same-sex attraction, which includes feelings of wishing for heterosexual attraction and/or being dissatisfied or disappointed in their orientation (Izzard, 2000). The emphasis for psychodynamic counselors theoretically, however, is the internalized homophobia and its remediation rather than coping with real experience of external homophobia in others. Thus, there is debate about how and whether to assume a more gay affirmative stance as a psychodynamic practitioner (Cornett, 1993).

Therapeutic Stance: Gay Affirmative vs. Neutrality: The heart of psychodynamic approaches is clinician neutrality, which allows for the client's patterns of relating and intrapsychic material to clearly emerge and be seen (Izzard, 2000). In most forms of psychodynamic counseling, there is no affirmation or reassurance. This strict form of neutrality can be helpful for addressing internalized homophobia. However, it precludes an analyst from taking a "gay affirmative" stance (Cornett, 1993; Izzard, 2000). By definition, a gay affirmative stance is not a neutral position. In practice, gay affirmative counseling involves taking an advocate stance, offering affirmation of the client's sexual orientation, and it may lead the counselor to preclude the exploration of the client's negative feelings about being gay. A gay affirmative stance includes greater attention to harassment and social realities. However, some worry that such a stance is an unhelpful overreaction to pathologizing same-sex attraction and does not allow the client to fully benefit from the psychoanalytic "working through" process (Shelley, 1998). Thus, Frommer (1995) recommends that analysts balance their commitment to neutrality that is critical to the analysis process, while maintaining a realistic awareness of the daily impact of homophobia and marginalization.

Psychodynamics of Bisexuality

Working with bisexual individuals requires sensitivity to their unique experiences (Friedman & Downey, 2010; Rubinstein, 2003). Bisexual individuals report attraction to both men and women, and each can vary in the homosexual/heterosexual balance over the course of a lifetime. Additionally, at different times in their lives, a person who experiences same-sex attraction may identify as heterosexual or homosexual depending on the sex of the partner. Like their gay counterparts, bisexual individuals must contend with internalized homophobia. However, in addition, many experience "biphobia," internalized self-oppression (Dworkin, 2001), as well as unrealistic expectations from self and others. Some assume that bisexuals "can't make up their minds" or "have a choice," which is often not the experience of bisexual attraction (Friedman & Downey, 2010). Instead, they typically report finding themselves "falling in love" with persons of either gender, creating confusion, complications, and significant life upheaval (Friedman & Downey, 2010). In addition, bisexual persons may struggle personally or interpersonally with negative assumptions, such as that bisexuality involves a fear commitment, fear their true homosexual identity, or inability to be faithful (Dworkin, 2001).

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From a psychodynamic perspective, the unconscious conflict of bisexual individuals is different from those with heterosexual and same-sex attraction (Friedman & Downey, 2010). When a person is consistently attracted to one sex, the erotic image is stable and constant. In contrast, in bisexuality, the erotic image can change; this change is often highly influenced by external factors, including traumatic events and anxiety from unconscious conflicts about one's sexuality. Thus, the analyst needs to thoughtfully examine the underlying dynamics that affect the heterosexual/homosexual balance in bisexual individuals. One such factor is the sexual orientation of the counselor (if revealed) and any value judgments a counselor may make about sexual orientation (Friedman & Downey, 2010); thus, counselors need to carefully consider their potential impact on a given bisexual individual when discussing sexual orientation.

Psychodynamic Case Study

Heidi, a 72-year-old woman, reports that her habit of worrying has gotten worse in recent years. She was a banking executive for years and retired at 68. Her parents fled Austria during World War II, settling in the United States after living for some years in South America. She describes her parents as proud people who worked hard to make a good life for her. Although they were ethnically Jewish, she says they were not very religious. She was born right before they fled, and thus her early years were turbulent, as her parents were focused on rebuilding their lives and mourning the loss of their parents in the camps; she does not have any siblings. She says that she was closest to her father, who was a quiet but warm person who encouraged her professionally. Her mother was stern and strict, focusing on her schoolwork and chores. Heidi still feels that her mother was disappointed that she did not do enough with her life. Heidi never got married or had a family but has several close friends whom she now considers family.

Case Conceptualization: Psychodynamic

This case conceptualization was developed by selecting key concepts from "The Viewing: Case Conceptualization" section of the psychodynamic part of this chapter. You can use any of the concepts in that section to develop a case conceptualization for this or other cases.

Levels of Consciousness

Because Heidi's anxiety and worry have a long history (she says that she has worried a lot most of her life), it is likely that there is a fair amount of unconscious material related to her current situation. In addition, given the intergenerational history of trauma and trauma at a young age, much of this may also be more unconscious than conscious.

Structures of the Self

As evidenced by Heidi's symptoms, history, and career choice as is common in her cultural background, Heidi has an overactive superego that in many ways helped her succeed professionally. However, at this point, it is creating increasing suffering. She describes her mother's criticalness as the primary source of her overpowering superego.

Drive Theory (Drive Theory and Ego Psychology)

In many ways, Heidi has redirected her libidinal energy into her work to avoid relationships and to find a consistent means of self-validation. After retirement, she has now lost this, and it is now causing her to doubt herself and self-worth more.

Secondary Gains

A secondary gain of her worrying is that she always has something to talk about with friends and a means to stay connected with them. She calls or asks to visit to share her latest concerns about finances, health, and so on. She generally gets sympathy or, if not, at least some social connection.

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Defense Mechanisms

Heidi has a history of *splitting* in her adult life as well as her childhood, where she saw her father as all-good and mother as all-bad. In her adult life, she periodically ends friendships when she feels that someone has not shown enough loyalty or caring. She also *represses* many of her more vulnerable feelings to avoid appearing weak and needy; although she worries, she does so with more anger and frustration than fear. She also *projects* a sense of being criticized onto others, often feeling insulted when no insult was intended.

Erickson's Psychosocial Stages of Development

In terms of her psychosocial development, two key issues stand out. First, she never developed a strong capacity for intimacy and instead focused on being a productive professional. Now that she is entering later life, she is struggling with feelings of despair and struggling to make sense of her life; she has repressed many of her earlier dreams and longings in favor of security but now is dealing with the repercussions of repressing these for so many years.

Object Relations Theory/True Self

Because of the upheaval and trauma in Heidi's family during her early years as well as her mother's emotional distance, Heidi has not resolved many of these early issues. She has internalized her mother's criticism and is quick to hear it from others. Although her father was more supportive, his approval never seemed enough to outweigh her mother's disapproval. In many ways, she still lives from the false self that she developed to please her mother.

Relational Matrix

Heidi's relational matrix has shrunk dramatically in recent years; thus, she has fewer people (or activities) to reflect back her worth. As she and her friends are older, she worries about her network of friends shrinking even more. Most of her friends are bright, former professionals who are active in local arts and music, as is she. This network creates a common bond that gives her something to look forward to.

Unconscious Organizing Principles and Culture

Heidi's father was a medical doctor in Austria before he fled with his young family early during World War II. The loss of their way of life and other family members has created a family expectation that ruin and doom are right around the corner. Having emigrated from Austria to South America and then to the United States, there was never a sense of being rooted or deeply connected. Their greatest joy—and a deep sense of safety—was derived from having a prestigious and lucrative career that creates stability and financial security.

Treatment Plan: Psychodynamic

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity considerations:* Adjust style and intensity of emotional expression based on client comfort level; attend to trauma symptoms when sessions are intensive; be respectful of age differences.
   Relationship-building approach/intervention:
   a. Use **empathy** and **mirroring** to provide a supportive, **holding environment** for the adult female (AF), maintaining awareness of her cultural/family background that devalued demonstrative emotional expression.

(*continued*)

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2. *Assess individual, systemic, and broader cultural dynamics. Diversity considerations:* Attend to issues of immigration, Holocaust, and Austrian, South American, and American social norms, especially in childhood.
   Assessment strategies:
   a. Analyze **unconscious conflicts** underlying anxiety and role of **defense mechanisms** in managing them.
   b. Assessment strategy: Analyze **object relations patterns**, including expressions in current relationships and historical development during childhood years when family fled from Nazis.
   c. Assessment strategy: Assess **relational matrix** and culturally defined **unconscious organizing principles** that shape the client's worldview, with careful attention to Austrian/Jewish values, legacy of the Holocaust, and her family's traumatic immigration story.

Initial Phase Client Goal

1. *Decrease* **emotional reactivity** to perceived criticism to reduce anxiety and worry.
   Interventions:
   a. Provide empathy using **understanding-explaining sequence** to reduce client's inaccurate perceptions of criticism from others.
   b. **Interpretation of relational** patterns with parents to reduce need to use **splitting and repression** in response to incorrectly perceived threats.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity considerations:* Carefully monitor and adapt expectations for her age, cultural, and professional norms for relating. Consider cultural and trauma issues before assuming client is projecting onto counselor.
   Assessment Intervention:
   a. Monitor and work through **transference and countertransference**.

Working Phase Client Goals

1. *Decrease* use of **splitting, repression, and projection** to protect self from feeling criticized by self and others to reduce worry/anxiety.
   Interventions:
   a. Interpretation of role of **defense mechanisms** and how it developed in early childhood immigration and trauma experiences and is being inappropriately used currently.
   b. Culturally sensitive analysis of **transference** in session when AF perceives counselor as critical and/or sees counselor as all-good or all-bad.

2. *Increase* **ego strength** and **self-cohesion** to reduce worry/anxiety.
   Interventions:
   a. **Mirroring** to confirm AF's sense of worth and value, with an emphasis on acknowledging vulnerable emotions.
   b. Empathy using the **understanding-explaining sequence** to increase client's sense of cohesion.
   c. **Dream interpretation and free association** to bring sources of inner conflict to conscious awareness, especially as they relate to early childhood/family traumas related to fleeing from the Nazis and immigrating.

3. *Increase* sense *of* **personal agency** informed by emotional intelligence to reduce social conflicts and engagement.
   Interventions:
   a. **Intersubjective responding** to increase client's awareness of self in sessions versus various emotional-relational contexts.
   b. **Working through resistance** to translating insight into action.

(*continued*)

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Closing Phase of Treatment

Closing Phase Counseling Tasks

1. *Develop aftercare plan and maintain gains. Diversity considerations:* Consider intergenerational loss issues related to immigration and holocaust; identify potential Jewish cultural community resources.
   Intervention:
   a. Analyzing **transference** and **abandonment** issues as impending termination approaches.

Closing Phase Client Goals

1. *Increase* sense of **integrity** related to past and current life decisions to reduce sense of despair as she faces end of life.
   Interventions:
   a. **Dream analysis, free association, and analysis of transference** to identify regrets and unresolved past traumas and losses.
   b. Enable client to **work through past** losses and traumas related to childhood as well as choosing to focus all her energies on her career and ignore her desire for relationship/family.
2. *Increase* ability to experience **mature dependency and intimacy** to reduce potential for using her anxiety to stay connected to friends.
   Interventions:
   a. **Analyze transference** and **secondary gains** and work through resistance to intimacy in in-session and out-of-session relationships.
   b. **Intersubjective responding** to critically examine the unconscious organizing principles the client uses to relate to others and how she builds relationships.

Questions for Personal Reflection and Class Discussion

1. What elements of psychodynamic theory seem most useful or "true" to you? Why?
2. What elements of psychodynamic theory seem least useful or "true" to you? Why?
3. With which type of clients would you be likely to have countertransference? How might you prevent this and/or recognize this dynamic?
4. Does a one-person or two-person counseling relationship make more sense to you? What experience do you draw from to support your answer?
5. In what ways might psychodynamics be a useful approach for working with specific diverse clients? In what ways might the approach need to be adapted for working with diverse clients?
6. Define ego strength in your own words and provide an example from your personal life.
7. Describe a moment of critical insight in your own personal dynamics. How did it affect you emotionally and behaviorally?
8. What are your thoughts on dream analysis? Have you analyzed any of your own? If so, how was it helpful?

Online Resources

Associations

Diversity considerations: In addition to those listed, most major cities have an association or institute for psychoanalytic studies, and many also have an institute dedicated to the work of C. G. Jung.

American Institute of Psychoanalysis
www.aipnyc.org

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American Psychological Association, Division 39, Psychoanalysis
www.apa.org

American Psychoanalytic Association
www.apsa.org

C. G. Jung Institute of Chicago
www.jungchicago.org

C. G. Jung Institute of Los Angeles
www.junginla.org

C. G. Jung Institute of New York and CG Jung Foundation
www.cgjungny.org

Center for Applications of Psychological Types (Myers-Briggs)
www.capt.org

Chicago Institute for Psychoanalysis
www.chicagoanalysis.org

International Psychoanalytic Association
www.ipa.org.uk

International Association for Relational Psychoanalysis and Psychotherapy
www.iarpp.org

Jungian Society for Scholarly Studies
www.thejungiansociety.org

Los Angeles Institute and Society for Psychoanalytic Studies
www.laisps.org

Myers-Briggs
www.myersbriggs.org

Psychoanalytic Institute of New York
www.psychoanalysis.org

Society of Analytical Psychology
www.jungian-analysis.org

Journals

Contemporary Psychoanalysis

Journal of Analytical Psychology
www.wawhite.org

Journal of the American Psychoanalytic Association
www.jungian-analysis.org/journal-of-analytical-psychology

Psychoanalytic Dialogues
www.apsa.org
www.theanalyticpress.com

Videos

See the Theory in Action Videos at Cengagebrain.com

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*Asterisk indicates recommended introductory readings.

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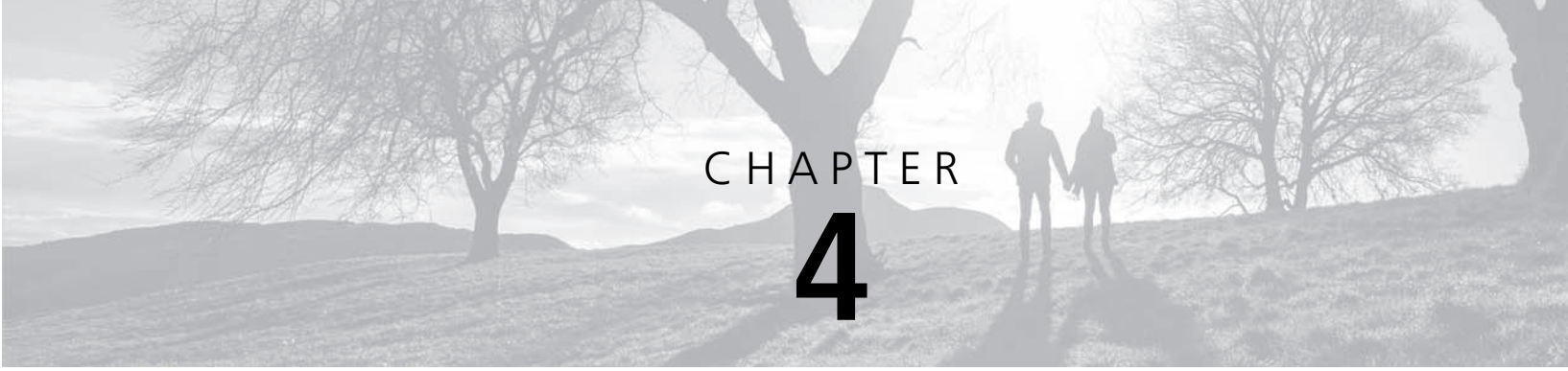

CHAPTER

4

Jungian Analytic Psychology

The unconscious is not just evil by nature, it is also the source of the highest good: not only dark but also light, not only bestial, semihuman, and demonic but superhuman, spiritual, and, in the classical sense of the word, "divine."

—Jung (1956a, p. 364)

Jungian Analytic Psychology

In a Nutshell: The Least You Need to Know

A distinctive approach that emphasizes cultural and spiritual elements, Jungian analysis is premised on the *collective unconscious*, a store of universal archetypes, myths, fairy tales, and experiences that are part of each individual's psyche and that can be used for psychological healing (Douglas, 2008). The goal of counseling is to build a relationship between the conscious and unconscious and the *ego* (how one sees and experiences the self) and the *Self* (a higher-order self that is whole and complete) to create a unique sense of individuality and connection with life, the cosmos, and the divine. Jungian counselors analyze dreams, synchronicity experiences, and life patterns by analyzing the archetypical, mythic, and legendary themes to help clients become more aware of material in the personal unconscious and collective unconscious.

The Juice: Significant Contributions to the Field

If there is one thing you remember from this part of the chapter, it should be …

Archetypes

Archetypes are unconscious universal patterns that can be traced across cultures and influence how people think, feel, and behave. Jung (1959a) defined them as typical modes of apprehension. They are powerful forces that can be either destructive or healing, depending on how a person relates to them. Certain archetypes exist in everyone, such as the Self, anima/animus, and shadow. Others express themselves only in certain people at certain times, such as the divine child, hero, trickster, mother, father, and so on. Some of the key archetypes are discussed next.

Ego Using the term differently than Freud, Jung's ego refers to a complex set of representations of oneself that has both conscious and unconscious elements that are both personal and collective (Hopcke, 1989). "Simply put, too simply perhaps, the ego is how one sees oneself, along with the conscious and unconscious feelings that accompany that view … [which] represents the very hard won self-awareness that makes us human" (p. 77).

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He believed that the modern idealization of the ego could lead to an imbalance with other elements of one's being, most notably the Self. In the case study at the end of this chapter, Martin, an African American business executive, struggles with depression; his Jungian analysis views his mood disorder as related to his overidentification with his ego to the detriment of the Self.

Self The Self (with capital S) is an archetype of wholeness that stems from a deeper connection with life and all humanity (Harris, 1996; Hopcke, 1989). The Self is a supraordinate, organizing principle of the psyche, in many ways incorporating all the others. The Jungian counseling process is designed to help people become more aware of the Self.

Shadow "The shadow is a moral problem that challenges the whole ego-personality, for no one can become conscious of the shadow without considerable moral effort. To become conscious of it involves recognizing the dark aspects of the personality as present and real" (Jung, 1983, p. 91). The shadow archetype represents the typically unpleasant, socially unacceptable, and immoral aspects of a person that are suppressed and/or unconscious; these can become the source of neurosis, psychosis, or compulsive behavior (Douglas, 2008; Hopcke, 1989). The process of counseling typically involves the process of addressing the shadow and its contents—which may or may not be negative—and learning to own them as part of the self even if not acted on.

Persona One of Jung's more practical and down-to-earth concepts, the *persona* is "the part of the personality developed and used in our interactions, our conscious outer face, our social mask" (Hopcke, 1989, p. 86). Serving as one's "public face," the persona plays an important role of mediating between the outer world and the inner world (Douglas, 2008). The persona is not inherently good or bad, but frequently it is the source of trouble when a person identifies with it rather than the Self.

Anima/Animus One of Jung's more controversial ideas, anima/animus developed from his observation that below the conscious masculine personality was a feminine side (anima); he later added but did not develop as fully the idea that women also have a masculine side (animus; Harris, 1996). The exploration of this archetype has had profound effects on our contemporary understandings of gender, and increasingly it is acceptable for both men and women to get in touch with and express qualities typically associated with the other gender. Jung believed that these remained primarily unconscious yet were important mediators between the ego and one's inner life.

Hero One of the most clear and undeniable universal archetypes, the hero plays an important role at a personal level as well as societal level and often serves as a persona (Harris, 1996). Jung identified several universal elements of the hero's story: a divine birth, descent into the underworld, overcoming near-impossible obstacles, and helpful companions, as well as themes of defeat, death, and rebirth. Although, like all archetypes, neither inherently good nor bad, Jung believed that overidentification with the hero often leads to problems commonly associated with hubris and overconfidence, namely, ultimate defeat and disgrace (Hopcke, 1989).

Wise Old Man or Woman Another readily identifiable archetype, the *wise old man* is found in most world cultures and represents humanity's collective wisdom as well as certain qualities of masculinity, namely, strength, quietness, and fortitude (Harris, 1996; Hopcke, 1989). The wise old woman, often appearing in the form of the Virgin Mary or Kwan-Yin, typically demonstrates feminine qualities, such as nurturance and forgiveness. The wise old man or woman archetype often makes an appearance toward the end of the counseling process as a client moves toward greater inner awareness.

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Trickster Ah, the trickster! The trickster often pulls one over on the counselor, too! The trickster is found in most world cultures: the court jester in Europe, the mythic Milarepa in Tibet, the Native American Kokopelli, and the Greek Hermes (Harris, 1996; Hopcke, 1989). The trickster is a master of speaking truth through paradox, is the first to proclaim that "the emperor has no clothes," and is the one laughing at a funeral. The quintessential shape-shifter, the trickster represents unexpected reversals and thus is a harbinger of transformation and change. In counseling, the trickster makes many appearances, often the unfortunate cause for seeking a counselor, the source of unexpected positive and negative turns during the process, and sometimes even the reason for a speedy end.

Try It Yourself

Find a partner and discuss an archetype that seems particularly relevant in your current life (note: healer is often an option for those reading this book). In what ways is this archetype playing out in your life? What were some of your first experiences with it? How is it helping you to grow?

Rumor Has It: The People and Their Stories

Carl Gustav Jung

Born in 1875 in a northeastern province of Switzerland, Carl Gustav Jung was born to a minister in the Swiss Reformed Church. Jung was a quiet and introverted child who was interested in anthropology, mysticism, and philosophy, interests that are clearly evident in the counseling approach he later developed. His mother was an eccentric woman who claimed to see and communicate with spirits and was often unavailable for her son.

Although Jung began studying medicine, he later switched his study to the less respected subject of psychiatry. In 1903, he published his dissertation, *On the Psychology and Pathology of So-Called Occult Phenomena*. In 1906, he sent a copy of a paper, "Studies in Word Association," to Freud, initiating a significant, productive, and historic—yet short—six-year friendship between the two men. Their friendship ended in 1912 when Jung published *Psychology of the Unconscious*, in which he diverged from Freud's thinking.

After serving as an army doctor in World War I, Jung returned home to marry Emma Rauschenbach, and they had five children. He continued to develop his theory, which was deeply spiritual, influenced by Christianity, Buddhism, Hinduism, Daoism, and other world religions that were just being explored in the West. He wrote the introduction to many of the first English translations of works such as *The Tibetan Book of the Dead* and *I Ching*. He was a mystic, believing that each individual could have direct contact with the divine, and his approach is an expression of this belief.

Big Picture: Overview of Counseling Process

Although many elements of the theory may seem too abstract and a far cry from typical presenting problems, in practice Jungian analysis is down-to-earth and practical, focusing on relieving suffering (Hopcke, 1989). Like Freud, Jung believed that resolution of client problems involved resolving unconscious conflicts by bringing to awareness repressed and suppressed thoughts and feelings. More so than Freud and other psychodynamic theorists, Jung was quick to abandon preconceived theory if doing so benefited an individual's treatment, because he believed that each person's journey toward individuation or wholeness was truly unique. Thus, rather than adhere to a strict set of interventions, Jung was creative and adaptive, using whatever seemed to be most useful to a particular client. He saw his role as more of a healer or guide, helping a client move toward greater integration of their inner polarities, of their unconscious and conscious

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minds, and of their ultimate connection to the cosmos. Jung (1956a) identified four stages of counseling:

1. *Confession:* In this first stage, clients recount or "confess" their life stories, which often creates a sense of *catharsis*, or emotional release. The counselor listens empathetically and nonjudgmentally, helping the client feel reconnected to another.
2. *Elucidation:* In the second stage, the counselor helps the client gain insight about the transference relationship as well as childhood memories that are related to the problem.
3. *Education:* Jung explains that the stage of education involves "pointing out that no amount of confession and no amount of explaining can make the crooked plant grow straight, but that it must be trained upon the trellis of the norm by the gardener's art. Only then will normal adaptation be reached" (p. 68). In this phase, insight is translated into meaningful new action.
4. *Transformation:* The final phase of transformation applies only to those clients who desire to seek individuation rather than simply symptom relief, which is generally achieved in the third stage. Jung focused the later half of his career on this phase and compared it to the medieval art of *alchemy*, in which alchemists tried to turn base metals into gold. Similar to alchemists who changed themselves as part of the process of transforming metals, Jung believed that the counselor must simultaneously make personal life changes before clients can achieve personal transformation. In this phase, clients become more consciously connected with their Selves and the collective unconscious.

Making Connection: Counseling Relationship

Collaborative Educators

The Jungian style in the counseling room is one of fellowship, the counselor *collaboratively* working with clients in pursuing their unique journeys of individuation. At times, the Jungian counselor also plays the role of *educator*, offering information and insight regarding the role of archetypes and meaning. In comparison to Freud, Jung maintained a more pragmatic "whatever-works" attitude that required a flexible role on the part of the counselor (Hopcke, 1989).

Healer, Heal Thyself

Jung viewed counselors as archetypal healers, and as such they must engage in the archetypal journey of healers to heal themselves. Jung emphasized that analysts must also go on this journey to help guide clients in this process. One's personal work with archetypes, the unconscious, and collective unconscious is the only way to help others do the same. Without intimate and personal knowledge of these vast, mysterious realms, counselors will quickly get lost. Since many elements of the journey of individuation are archetypal, once the counselor has made significant progress on his or her own journey, it becomes much easier to help clients on theirs. Thus, similar to other depth psychologists, Jungian counselors engage in their own analysis as part of their training.

The Viewing: Case Conceptualization

Collective Unconscious

A significant departure from other forms of depth psychology, Carl Jung posited the *collective unconscious*, which exists beyond the individual and represents the evolutionary mind of humanity, including archetypes, myths, images, and symbols that can be traced in cultures throughout the world. Jung believed that the universal unconscious was *in addition to* the conscious and unconscious mind described by Freud. Jung states, "I have chosen the term 'collective' because this part of the unconscious is not individual but universal; in contrast to the personal psyche, it has contents and modes of behaviour that are more or less the same everywhere and in all individuals. It is, in other words, identical in all men and thus constitutes a common psychic substrate of a suprapersonal nature which is present in every one of us" (Jung, 1959a, pp. 3–4).

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The structure of the personality as described by Jung included the following:

- *Conscious mind:* The part of the mind that one is aware of; contains the ego
- *Personal unconscious:* Includes forgotten elements, repressed memories, and elements that never were conscious (Harris, 1996)
- *Collective unconscious:* A universal consciousness made up of archetypes that all individuals have access to

Complexes and Catharsis

Early in his career when working with spontaneous word association, Jung noticed that certain emotionally charged patterns emerged that were clearly related to a person's pathology (e.g., themes of sadness and loss in response to words like "hopscotch" or "jungle gym"; Harris, 1996; Hopcke, 1989). He referred to these emotionally charged sets of responses as *complexes*. Potentially conscious but more typically unconscious, Jung believed that all complexes have archetypal elements that need to be explored. The analysis process brings these complexes to conscious awareness so that the person can reinterpret, make new associations, and experience *catharsis*, or emotional release.

Polarities and Enantiodromia

Jung believed that many forms of psychopathology developed around *polarities*: personality traits that get magnified or minimized (Hopcke, 1989). For example, working too hard without creating space for play and relaxation quickly leads to an unbalanced life and eventually pathology, such as depression, anxiety, or social withdrawal. Thus, even a virtuous quality—such as a "good work ethic"—can be the source of problems if it becomes polarized. In the case study at the end of the chapter, Martin is struggling with the polarity of responsibility and freedom: he has been an exceptionally responsible father, husband, and businessman but has become depressed because he feels an increasingly loss of freedom in his life. His greatest personal strength—when taken to an extreme over time in his life—has become a significant source of pain. Working through this paradox can be a particularly difficult struggle that requires insight and the ability to embrace complexity.

In his conceptualization of psychological types, Jung conceptualized personality elements as polarities and believed that maturity involved a healthy balance of any two polarities. A related concept, *enantiodromia*, refers to Heraclitus's law that "everything sooner or later turns into its opposite" (Douglas, 2008, p. 117). This process is commonly seen in those who try to pursue ultrapure forms of spirituality and abstinence; they often are caught indulging in extreme forms of sexual misconduct, substance abuse, or frivolous extravagance (I won't name names, but you can probably call to mind a few examples from yesterday's newscasts). Similarly, many who pursue extreme forms of fame often find themselves in a similar situation.

Psychological Types

One of Jung's most enduring works, his theory of psychological types involves three elements, each consisting of two polarities:

- *Extravert/Introvert: Describes general attitude and orientation*
  Terms now used by nonprofessionals, Jung originally used the terms *extravert* and *introvert* to refer to a person's basic approach to libidinal energy. Extraverted refers to the individual's energy more typically being directed from inside the self to the outer world: "Extraversion is characterized by interest in the external object, responsiveness, and a ready acceptance of external happenings, a desire to influence and be influenced by events, a need to join in" (Jung, 1983, p. 140). In contrast, the introvert's libidinal energy more often moves from the outer world toward the self: "Introversion … being directed not to the object but to the subject… holds aloof from external happenings, does not join in. For him self-communing is a pleasure. His own world is a safe harbour, a carefully tended and walled-in garden" (pp. 141–142). Neither being better than the other and each having an important role in psychological health, the focus in counseling is to find a healthy balance between the two.

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- *Thinking/Feeling*
  Jung described how people organize information and make decisions on the basis of two styles: thinking or feeling. Thinking types prefer analysis and logic, whereas feeling types focus on values and morality (not necessarily emotion). Understanding a person's type helps to better understand his or her motivations and reasons for making a decision.
- *Intuitive/Sensing*
  Finally, Jung characterized a person's typical style of "experiencing" the world as either intuitive—relying heavily on unconscious and collective unconscious information—or sensing—relying more on information through the senses. Counselors can use the knowledge of a person's preference for experiencing to develop interventions that "make sense" to the client.

Myers-Briggs Developed by a mother-daughter team, the well-known Myers-Briggs typology used in business, college counseling, and numerous other arenas are based on Jung's personality characteristics. They have developed instruments that are commonly used to determine a person's type (Myers, 1998). Myers and Briggs added one more dimension to Jung's three: judging/perceiving:

- *Judging/Perceiving*
  Judging and perceiving refer how one orients to outer life. Judging types prefer to have things planned, ordered, and organized; they feel most at ease after a decision has been made. In comparison, perceiving types enjoy the process of exploring possibilities and have a spontaneous approach to life; they like to take in new information and experiences.

In addition to the traditional adult version, a version for children has also been developed: the Murphy-Meisgeier Type Indicator for children (McPeek & Breiner, 2013).

Targeting Change: Goal Setting

Individuation

The goal of Jungian analysis is to build a relationship between the conscious and unconscious and the ego and Self to create a unique sense of individuality while still connected to the larger human experience (Hopcke, 1989); this process is called *individuation*. Like humanists (Chapter 6), Jung believed that the human spirit naturally moves toward and seeks wholeness, which is represented in the archetype of the Self and is fundamental to his approach. The journey toward wholeness involves reconciling polarities and opposites within the psyche, increasingly bringing to consciousness the multifaceted elements of one's humanity. Jung saw the individuation process as the primary focus during the second half of life, after the achievements of young adulthood are well established (Jung, 1956b).

Example of Goals

- Facilitate catharsis related to childhood experiences (early phase)
- Increase awareness of persona and how it is maintained (early and middle phase)
- Increase awareness and acceptance of shadow elements of the self (middle and late phase)
- Integrate shadow elements into conscious understanding of self (middle and late phase)
- Increase sense of wholeness and well-being (late phase)
- Increase sense of connection to others, humanity, and/or the divine (late phase)

The Doing: Interventions

Symbols

Jungian counselors attend to *symbols* in clients' dreams (see below), choice of metaphors, synchronistic events (see section "Synchronicity"), symptoms, fantasies, and other material. Jungians view symbols as pointing to meanings that are not yet fully understood, which they distinguish from signs that are simply representational of a known

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thing: "Symbols provide the way out of a dilemma, a transcendent coming together of the opposites" (Harris, 1996, p. 56). Clinicians help clients (a) identify personally relevant symbols, (b) decode their personal meaning for clients, and (c) use them to promote healing. For example, a swan may become an important symbol for a woman who is struggling to accept her body image; the symbol may appear in her dreams, be part of synchronistic chance happenings, and become a personal symbol of healing for her. The fairy tale *The Ugly Duckling* may be an inspirational story for the woman as she embraces her physical beauty in new ways. The counselor can help guide her in how to use the symbol to help her interpret her life and inform new attitudes and behaviors.

Dream Analysis

As in Freudian psychoanalysis, dream analysis is a hallmark technique of Jungian analysis. Both Freud and Jung agreed that dreams revealed unconscious material, but because they had quite different definitions of the unconscious mind, they approached dreams quite differently. Freud believed that dreams served the purpose of dealing with suppressed libidinal and aggressive impulses that the dreamer could not consciously recognize; Freud analyzed virtually all dreams through this lens. In contrast, Jung had a more intuitive and varied approach to dreams. He believed that the dreams were the unconscious expressing itself—sometimes expressing repressed material, sometimes foreshadowing the future, and sometimes providing direction to the individuation process—using its native language: symbols. The dream needed to be interpreted for the conscious mind to understand it and use it in the individuation process. "The point of dream work for Jung was to arrive at an interpretation or a set of interpretations that united conscious understanding and unconscious processes in a way that was intellectually, emotionally, and intuitively satisfying" (Hopcke, 1989, p. 26).

Jung's dream analysis employs a combination of using universal archetypal symbols and myth combined with the dreamer's unique associations and meanings. Ultimately, as in Freud's approach, the dream must be interpreted using the dreamer's unique meanings. Generally, Jungian dream interpretation involves three phases:

Jungian Dream Interpretation

Step 1: Identify dreamer's associations: As or after the dreamer shares the dream, the counselor asks about the dreamer's associations to significant people, places, events, and items in the dream.

- What were the details that stood out in the dream and/or continue to linger (size, shapes, colors, objects, places, general feeling)?
- Were the elements of the dream familiar or unfamiliar?
- Were the elements new, old, current, future, or of a distant time?
- What was the dreamer's emotional state(s) in the dream?
- After waking (and in session), what emotional response did the dreamer have?
- Even if the dream does not have specific references, does the dream remind the dreamer of anyone, a place, or time in any way?

Step 2: Identify universal symbols/symbol amplification: In a process called *symbol amplification*, the analyst identifies potential archetypal elements in the dream (Hopcke, 1989).

- Are elements of the dream reminiscent of myths, legends, or folktales?
- Do any of the characters or elements represent an archetype? If so, how are these elements represented—positively, negatively, traditionally, untraditionally?
- Are there specific symbols that stand out, especially elements that had a strong emotional charge?

(*continued*)

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Step 3: Consolidation of interpretations: Finally, the counselor and dreamer work together to consolidate the two possible sets of interpretations into one or more interpretations that resonate and have significant personal meaning for the dreamer.

Try It Yourself

Find a partner or use a journal to analyze a recent dream using the steps above.

In the case study at the end of the chapter, Martin and his counselor analyze a recurring dream he has had about being put in jail by a laughing guard, who cackles, "you are never going to get out." The jailor then swallows the key. A Jungian counselor would work with Martin to analyze the many layers of the dream, which in this situation apply to both his home and work life. It may seem particularly difficult to a client such as Martin who has strong ego identification to recognize how he may feel both "trapped" as well as joyous about news of a third child. Similarly, recognizing that he feels "jailed" by his high-paying job—for which he is also grateful—can also be a threatening reality to acknowledge due to the implications for him and his family. Dreams often help highlight complex and contradictory emotions.

Active Imagination: Dreaming the Dream Onward

A technique related to dream work, *active imagination* helps develop a person's relationship to their unconscious mind and archetypes (Hall, 1986; Harris, 1996; Hopcke, 1989). In most dreams, the dreamer is a passive recipient of the unconscious, which writes the story, casts the parts, and directs the show. In active imagination, the client uses content that has been received from the unconscious through dreams or other means and combines it with conscious intent to promote healing and transformation. The goal is to have the conscious and unconscious minds work in tandem to balance and correct problematic polarities. Thus, it is not allowing the ego to have wild fantasies or simply replaying dreams. Instead, it is typically a visualization technique in which the person bridges these two worlds. For example, new endings can be created for nightmares that enable the dreamer to experience a new response to a frightening situation. The person begins by imagining herself back in the dream, calling to mind the various elements, and then allowing the mind to spontaneously play with the scene and explore what unfolds when the conscious mind is allowed to spend time in this environment.

Jungian Analysis of Transference

Like other depth psychologists, Jungians believe that transference plays an important role in the counseling process, but they have a unique three-stage approach (Douglas, 2008; Jung, 1959b). In the first stage, the clients' projections relate to their personal histories, typically from childhood. During this phase, the counselor helps the client recognize that these projections belong to the client and has the client withdraw them from the counselor and integrate them into their own personalities. For example, if a client projects harshness onto the counselor, the counselor helps the client recognize the projection and to accept the harsh aspects of the self, whether directed at the self or others. In the second phase, the client learns to discern which elements of projection are personal and which are archetypal, a unique element in Jungian analysis of transference. This phase involves identifying cultural, gender, and archetypal elements of projections. In the final phase, the personal reality of the counselor is differentiated from the projected image, and a human-to-human connection is made.

Jung further clarifies that counselors have a profound and deeply personal responsibility related to transference. At one level, the counselor must be aware of typical countertransference issues, as is common in all psychodynamic approaches. But Jung goes further: "The doctor knows—or at least he should know—that he did not choose this career by chance; and the psychotherapist in particular should clearly understand that psychic infections, however superfluous they seem to him, are in fact the predestined

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concomitants of his work, and thus fully in accord with the instinctive disposition of his own life. The realization also gives him the right attitude to his patient. The patient then means something to him personally, and this provides the most favourable basis for treatment" (1959b, p. 177).

Synchronicity

Synchronicity refers to uncanny and meaningful coincidences that cannot reasonably be explained by chance: "When coincidences pile up in this way one cannot help being impressed by them—for the greater the number of terms in such a series, or the more unusual its character, the more improbable it becomes" (Jung, 1960, p. 105). For example, you think of a friend you have not spoken to in years, and the next day he calls; you have a dream about a diamond, and the next day you find yourself stuck in traffic behind a Diamond Plumbing truck while passing a Diamond Cleaners, and later that day your coworker shows you her new diamond ring; or your Jungian analyst explores your hero archetype, and you find yourself coming across superheroes in various media for the rest of the week. Jung believed that these experiences could not be explained without the hypothesis of the collective unconscious. Counselors interpret synchronistic events as information from the collective unconscious about what themes or archetypes the person should be attending to in order to facilitate the process of individuation.

Interventions for Special Populations

Sand Play

A distinct form of intervention, sand play is a highly developed Jungian approach to using a sand tray with miniature figures; it is distinct from the more generic use of sand tray that can be used from any counseling approach. Sand play was originally developed by Dora Kalff, a Jungian analyst with an interest in Buddhism "who recognized that Sandplay provided a natural therapeutic modality for the child, allowing the expression of both the archetypal and intra-personal worlds, as well as connecting the child to outer everyday reality" (Mitchell & Friedman, 1994, p. 50). Kalff believed that sand play could activate the psyche toward wholeness and healing by reestablishing a connection between the ego and Self (Boik & Goodwin, 2000). Although originally developed for children, sand play is commonly used with adults, especially those working through trauma and loss, as well as couples and families. In contrast to more generic forms of sand tray work, in sand play the counselor quietly observes as the client develops a scene in the sand with the figurines without offering interpretations until after several trays have been completed.

The Sand Trays Sand play counselors use specific dimensions for the sand tray, dimensions that allow the mind to easily "take in" the scenes created in the sand. Sand trays should be 28.5 inches by 19.5 inches with a depth of 3 inches and set on a table with a height of approximately 30 inches. The trays are typically painted blue on the inside to represent water or sky, and a very fine grade of sand fills the tray (see Figure 4–1). A formal sand play room has both a "dry" and a "wet" sand tray (and a frequently used vacuum for between sessions).

Photo by Rie Rogers Mitchel

FIGURE **4.1.** Sand Tray with Chaotic Themes (Child)

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Figurines The figurines in sand play are typically kept on open shelves so that each is easily visible (see Figure 4.2). In the Jungian approach, they are organized in "evolutionary" order with inanimate, natural objects at the bottom (e.g., rocks); then plants and foliage; and then dinosaurs, sea creatures, reptiles, birds, mammals, humans, and finally divine beings on the top shelf. (*Note:* Sand play requires more tidiness than most other forms of intervention.)

Introducing the Tray Once the counselor has established rapport and believes that sand play would be an appropriate intervention, the counselor introduces the activity using nondirective prompts, such as "Would you like to do a Sandplay? … Put in what speaks to you" (after pointing to the collection of figurines) (Mitchell & Friedman, 1994, p. 54).

Counselor Role The counselor's primary task is to create a free and protected psychological space in which the client feels comfortable exploring and yet protected and within safe limits (Mitchell & Friedman, 1994). Typically, the counselor sits off to the side and silently observes while the client works in the sand creating a scene with the figurines. Interpretations are *not* offered at the time the scenes are completed; instead, the counselor waits until after several trays have been completed to discuss them with clients (see Figure 4.3). The counselor's quiet, supportive, and trusting presence enables the client to more easily access and express their unconscious to facilitate a healing process.

Recording In most cases, the counselor will take a photograph of each tray after the client leaves for use later in the counseling process when the client is ready to explore the symbols and meaning in the tray. If a camera is not available, and/or in addition to the photograph, the counselor can also make a sketch of the tray while the session is in progress (Mitchell & Friedman, 1994).

Photo by Rie Rogers Mitchel

FIGURE **4.2.** Sand Tray with Fragmented Themes (Child)

Photo by Rie Rogers Mitchel

FIGURE **4.3.** Sand Tray Near End of Sand Play Process: More Coherency and Areas of Safety

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Putting It All Together: Jungian Case Conceptualization and Treatment Plan Templates

Theory-Specific Case Conceptualization: Jungian Analysis

Use the prompts below to develop a theory-specific case conceptualization; the case study at the end of the chapter provides an example.

Ego Identity

Describe how the client defines and/or sees him/herself, along with any notable unconscious.

Collective Unconscious

Describe any aspects of the collective unconscious that seem particularly notable in the client's life. This may be related to cultural, racial, religious, or broader community themes or particular myths or fairy tales that seem to be playing out in the client's life in some way.

Awareness of Self

To what degree and in what ways is the client aware of Self as conceptualized in Jungian analysis?

Shadow

What elements of the Shadow are operating in the client's life, either directly or indirectly related to the problem?

Archetypal and Mythical Themes

Identify archetypal themes in dreams, imagery, and life patterns. These may be related to one or more of the following:

- Anima/Animus
- Hero
- Wise Old Man or Woman
- Trickster

Polarities

Identify any polarities that may be related to presenting issues, such as those around:

- Work/Play
- Perfection/Failure
- Kindness/Cruelty
- Emotion/Logic
- Responsibility/Freedom

Complexes

Describe any complexes or notable archetypal themes.

Personality Types

Describe how the client's functions in each of the four/eight areas of the Myers-Briggs, highlighting how particular dimensions may be related to the presenting issues.

- Extravert/Intravert
- Thinking/Feeling
- Intuitive/Sensing
- Judging/Perceiving

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Treatment Plan Template: Jungian Analysis

Use this treatment plan template for developing a plan for clients with depressive, anxious, or compulsive types of presenting problems. Depending on the specific client, presenting problem, and clinical context, the goals and interventions in this template may need to be modified only slightly or significantly; you are encouraged to significantly revise the plan as needed. For the plan to be useful, goals and techniques should be written to target specific beliefs, behaviors, and emotions that the client is experiencing. The more specific, the more useful it will be to you.

Treatment Plan

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration:* [Describe how you will specifically adapt your approach to be sensitive to client diversity when developing the counseling relationship; this may include respecting cultured and gendered norms for emotional expression.]
   Relationship building approach:
   a. Create a "**collaborative educator**" relationship in which client views counselor as a resource on personal journey of healing and individuation.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* [Describe how you will specifically adjust assessment based on cultural, socioeconomic, sexual orientation, gender, and other relevant norms.]
   Interventions:
   a. Assessment strategy: "**Confession**" or telling of unedited life story.
   b. Assessment strategy: Identify prominent conflicts related to **archetypes**, **polarities**, **complexes**, and **shadow elements of self**.
   c. Assessment strategy: Identify **Myers-Briggs psychological type**.

Initial Phase Client Goals

1. *Decrease* **unconscious conflicts** that escalate to crisis to reduce [specific crisis symptoms].
   Interventions:
   a. Analysis of **complexes**, **polarities**, and archetypal patterns that fuel crisis.
   b. **Active imagination** to increase coping skills and develop alternative responses to crisis.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* Account for diversity issues and personality types in maintaining working alliance.
   Assessment Intervention:
   a. Monitor and analyze **transference**; adapt relationship to accommodate **personality type**.

Working Client Goals

1. *Decrease* **unconscious conflict** and **complexes** related to [specify problem or context] to reduce [specific symptom: depression, anxiety, etc.].

(*continued*)

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Interventions:

a. Analysis of **childhood experiences**, **symbols**, **dreams**, and **archetypes** to bring unconscious conflicts to conscious awareness and allow for catharsis.
b. Analysis of **synchronicity** of conflict to understand conflicts and identify their role in individuation process.

2. *Increase* awareness of role of **persona**, **shadow**, and **Self** as well as role of [specify **archetype**] to reduce [specific symptom: depression, anxiety, etc.].
Interventions:
a. Analysis of **childhood experiences**, **symbols**, **dreams**, and **archetypes** to bring unconscious archetypal conflicts and shadow elements of self to conscious awareness.
b. Sand play to explore dynamics of persona, shadow, Self, and other archetypes.

3. *Increase* **integration of polarities** in personality and consciousness to reduce [specific symptom: depression, anxiety, etc.].
Interventions:
a. Analyze **transference** to identify and integrate polarities.
b. Analyze **synchronistic** events to facilitate integration of polarities.

Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity consideration: [Describe how you will access resources in the communities of which they are a part to support them after treatment ends.]*
Intervention:
a. Educating client on how to use analysis of **synchronicity**, **dreams**, and **symbols** to independently continue lifelong process of **individuation**.

Closing Phase Client Goals

1. *Increase* ability to consistently connect with and act from **Self** to reduce potential for relapse in [specific symptom: depression, anxiety, etc.].
Interventions:
a. Educating client on how to analyze **dreams**, **symbols**, and **synchronistic** events with increasingly less assistance from counselor.
b. **Active imagination** to consciously transform conflicts and complexes.
c. Use of personally meaningful symbols to solidify connection with **Self**.

2. *Increase* **sense of connection** to others, humanity, and the divine to reduce potential for relapse in [specific symptom: depression, anxiety, etc.].
Interventions:
a. Educating client on how to increase tolerance of other **personality types** and alternative ways of being in the world.
b. Use of personally meaningful **symbols** and **synchronicity** to solidify connection with divine.

Research and the Evidence Base

Research on the effectiveness and outcomes of Jungian psychology is limited, with single case study reports the most common form of research (Douglas, 2008). In one German study, 76% of long-term Jungian analysis patients showed a significant reduction in health insurance claims five years post-services, thus suggesting the cost-effectiveness of long-term analysis (Keller, Westhoff, Dilg, Rohner, & Studt, 2002). In a small-scale study with families, Kaplan, Saayman, and Faber (1981) used quantitative and

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qualitative analysis to accurately diagnose problem areas, family transactions, and treatment outcomes based on the analysis of dream content.

The most researched application of Jung's ideas is the MBTI. Most of the recent research on the MBTI has focused on developing translations of the instruments. Specifically, recent studies have examined the validity of several translations, including Turkish (Atay, 2012), Korean (Sim & Kim, 1993), Slovak (Ruisel & Ruiselová, 1995), and Chinese (Broer & McCarley, 1999). A study by Loffredo and Opt (2006) examined the correlation between MBTI personality type and argumentativeness; they found that Thinking and Intuitive types were more argumentative than Sensing and Feeling types. In a study with 6,280 participants examining MBTI type and academic performance, DiRienzo, Das, Synn, Kitts, and McGrath (2010) found that Judging types generally had a higher grade-point average than Perceiving types. They also found that across all majors (except for those in business) Introverted, Feeling, and Judging types had higher than average grade-point averages. They also found differences related to academic majors, with Intuitive, Feeling, and Perceiving types drawn more to the fine arts.

Tapestry Weaving: Applications with Diverse Populations

Cultural Diversity

The Jungian concept of the collective unconscious provides a formal conceptual means for acknowledging and analyzing the impact of a person's community and culture on an individual's psyche (Stein & Jones, 2010). Jungian practice readily invites and embraces the folklore, myths, and symbols of a client's culture, valuing the wisdom and life lessons that these cultural traditions seek to impart. Thus, more so than other analytic approaches, Jungian analysis provides a theoretical foundation for working with diversity. Furthermore, the Jungian emphasis on spirituality and archetypes has unique implications when working with religious and spiritually oriented clients. Unlike many other approaches, Jungian analysis invites and encourages the integration of spirituality and religious symbols in the counseling process. For example, archetypes of sinner and saint can be used to deepen a Christian client's understanding of self as well as to deepen and clarify the client's relationship to God. However, when used without attention to sociopolitical inequities and oppression, applications of the approach have been described as "essentialist" or even "racist" (Roper, 1992). For example, the Jungian goal of pursing individuation is heavily laden with Western values of separateness and independence, which may not be appropriate for clients from more collectivist cultures. Similarly, the Jungian concepts of animus and amina can also be used to reinforce stereotypical male and female behavior and gender roles.

Jungian analysis also has distinct expressions in multicultural contexts. Heyer (2012) notes that when a person lives within several different cultures with differing value systems the process of individuating—paradoxically separating oneself from the collective while still living peaceably within it—takes on multiple forms of complexity. Persons whose lives straddle more than one culture are part of multiple collective unconsciousnesses from which they must step back and question and yet ultimately learn to work within. When working with multicultural clients, Jungian counselors need to cautiously explore symbolism in the analysis process because the client will draw from multiple meaning systems. For example, the meaning of a given symbol (e.g., scarf) in the dream of an immigrant Iranian American Muslim woman must be considered from the possible collective meanings of Iranian women, American woman, American Muslims, Iranian Muslims, and immigrants; multiple layers of collective meanings are possible based on her socioeconomic situation in each culture (e.g., elite wealth, rural, etc.). In sum, Jungian concepts offer fruitful and significant ways to engage a client's culture in the counseling process; however, the approach must be applied with critical analysis of its inherent cultural bias for Western values.

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Japanese Applications

Jungian analysis is one of the more influential Western approaches in Japan (Kitanaka, 2003; Kawai, 2008). One reason this approach has particular relevance in Japan is that the concept of collective unconscious provides a useful and concrete means of acknowledging the role of community in an individual's psyche and inner world. As a distinctly collectivist culture, the importance of considering the effects of one's actions on family and community is a fundamental value, which is not readily addressed in other Western forms of therapy. Furthermore, the concept of collective unconscious invites the long and rich traditions of Japanese myth and folklore into the counseling room, enabling clients to connect to the process through that which is familiar and trusted. The Jungian approach provides a forum for exploring the conflict of premodern and modern Japan, both of which continue to have a presence in Japanese consciousness (Kawai, 2010).

Another reason Jungian approaches have been embraced in Japan is that the approach uses unique modalities such as sand play, dream analysis, and art to engage clients (Kawai, 2010; Kitanaka, 2003). These methods, particularly Jungian sand tray, have been popular in Japan because they allow clients to experience a self-directed process of self-discovery without having to verbalize feelings and thereby reducing potential shame in revealing embarrassing information, a significant value in Japanese and East Asian cultures more generally (Kitanaka, 2003). Thus, Japanese clients value the indirect and creative means for addressing emotionally difficult material. Kawai (2010) further notes that verbally interpreting symbols in these therapeutic activities is not helpful to all Japanese clients; instead he recommends that the symbolic play or art or dream not be verbally analyzed and tied to psychological material when working with some Japanese clients. Instead, he suggests that change seems to naturally happen when these two parallel worlds—discussion of the problem and symbolic sand play, art, or dreams—are allowed to coexist without attempts to connect them verbally. He compares these two parallel worlds to the premodern and modern worlds that also coexist in contemporary Japanese consciousness; both of which exist side-by-side yet do not interact meaningfully.

The popularity of this approach has also been attributed to its ability to allow for rich analysis of the Japanese self (Kitanaka, 2003). In contrast to Western folktales that portray heroic journeys of overcoming hardship to find true love, Japanese folktales have more ambiguous endings that often highlight that "nothing" happened. The Japanese stories emphasize material aspects of nurturing and care (i.e., relational connection) over the paternal aspects of power and activity (i.e., something happens). The importance of the maternal images has increased in recent years because increasingly, fathers are absent from the family, working long hours while the mother remains the primary parent caring for children (Kitanaka, 2003). These themes of the maternal and paternal in contemporary Japanese culture can be explored through Jungian analysis.

Sexual Identity Diversity

Historically, Jung had little to say about homosexual attraction because, in general, he tended to have a more symbolic approach to sexuality, especially in comparison to Freud (Haslam, 2000). Where he did mention it, he viewed these "contrasexual tendencies" as a form of regression. Nonetheless, more foundational to his approach is the overarching imperative that the individual journey toward wholeness not be constricted or constrained by collective and social attitudes. This valuing of each person's unique journey of individuation has provided a fertile foundation for the exploration of alternative sexualities in contemporary Jungian practice.

With its emphasis on interpreting the symbols of the unconscious, Jungian analysis has the potential to bring a refreshing perspective to working with same-sex attraction (Miller, 2010). Rather than trying to develop a "theory of homosexuality," the Jungian approach seeks to deepen the client's relationship to and understanding of his or her psyche. In this search, dream images and fantasies are explored for their underlying meanings and symbols as part of the individual's search for wholeness. Within the contemporary Jungian framework, same-sex attraction and alternative gender identity are seen as neither pathological or healthy, but rather as an invitation to deepen one's

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knowledge of the psyche: "Essentially this is the work of giving up expectations of controlling or shaping it [one's sexuality] and seek, instead, a relationship to the factor that creates our sexualities, the creation of our lives, to learn what is embedded in Nature's urgent demands upon the psyche" (Miller, 2010, p. 123).

When working with sexual minorities, Jungian analysts pay particular attention to the client's archetypes of self, shadow, anima, and animus. Given that sexual minorities experience a significant sense of marginalization and shame, the pursuit of wholeness involves acceptance of the client's shadow, the parts that have been denied and rejected (Haslam, 2000). Furthermore, because sexuality is closely intertwined with the experience of gender, the archetypes of anima and animus often are particularly significant when working with those who identify with alternative sexual and gender identities. That said, Haslam (2000) cautions that traditional interpretations of these gender archetypes can be problematic for sexual minorities because Jung tended to idealize anima and pathologize animus. Thus, Haslam encourages a more contemporary and less essentialist approach to these archetypes with gay, lesbian, and bisexual clients.

Masculine Archetype in Lesbian Families

Jungian theory provides a unique lens through which to understand gender archetypes in same-sex relationships and families. Weston (2008) describes how Jung's theory of individuation and archetypes can be used in lesbian families raising boys. According to Jung, the process of individuation involves realizing one's innate and full potential, engaging all aspects of the self, especially the shadow and opposites tensions within the self. Weston identifies two polarities that are of particular relevance for lesbians: a) society's familiar versus other (heterosexuality versus homosexuality), and b) male/female. The coming out process—at minimum—requires individuation around these two polarities as a person learns to identify with that which society as defined as "other" and to explore potential gender identities, sex roles, and sexuality. Jungians would argue that all people have both male and female aspects of the self; the more one is aware of and able to embrace these elements of the self, the more fully individuated one becomes.

As a sexual minority, lesbians typically engage in a more conscious exploration of their gendered selves as part of their identity development and coming out process. In this process, they gain a more poignant awareness of gender-conforming and gender-nonconforming parts of themselves. Thus, when they transition to parenthood, both partners of a lesbian couple will typically parent in both male and female ways. Boys are thus exposed on one level to the masculine and feminine through their parents' embodiment of these archetypal ways of being in the world.

Weston also suggests that lesbian families can expose boys to the masculine through communal activities, most notably sports. The masculine principle is goal-oriented and seeks to conquer and master others and the external world (Weston, 2008). For many children, particularly young boys, this masculine energy finds its direction in the hero myth and archetype: the hero embodies a journey to pursue one's highest aspirations by overcoming obstacles and enemies. One of the most common expressions of this in contemporary American culture is organized team sports. Sports allow boys to safely engage in heroic activities of the male archetype: competing, goal seeking, striving, struggling, failing, improving, and conquering. Through sports, boys have multiple opportunities to enact and embody the masculine and learn to develop themselves through the heroic trials they represent. Sports or any similar activity that enables boys to strive for success and activate the masculine and hero archetypes can be of particular relevance for lesbian families wanting to support boys in their individuation process.

Jungian Case Study

Martin is a 41-year-old African American business executive at a large aerospace company who is seeking therapy due to his feelings of depression and anxiety, and the occasional angry outburst at his wife. He states that over the last three years he has found it to be a "chore" to go to work and finds that he comes home depressed and unmotivated.

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Martin states that he doesn't know why he is depressed as he has a "wonderful family and a well-paying job" where he is respected and comfortable. Martin has two sons, one in junior high and the other in high school, who he loves very much and is involved greatly in their lives. Martin's wife is currently pregnant with their upcoming daughter, to which he replies, "It's a miracle. We tried to become pregnant six years ago, but believed it was never going to happen. My wife always wanted a daughter." Recently, Martin has been having a reoccurring dream of being in a jail cell while a guard walks by chuckling, "You're never going to get out." The guard then looks at Martin and swallows the key to his jail cell, laughing hysterically. Martin finds himself yelling back at the guard, "But I did nothing wrong, I'm a good person." To which the guard shrugs and disappears.

Case Conceptualization: Jungian

Ego Identity

Martin describes himself as a committed father and husband. He sees himself as a competent provider for his family both financially and emotionally. He also prides himself as a successful business executive in being able to work his way up the corporate ladder and earning a high paying salary. He sees himself as a role model of success for other African American males and as an agent to help shift negative stereotypes about African American men. Unconsciously, though, Martin's ego identity as a competent provider may hinder him from acknowledging certain unconscious parts of himself that don't fit within this identity. Martin may be unconscious of his desire to change careers and find one that is more challenging and self-fulfilling. He may also be unconscious of his anger and the desire to not have another child and return to being a parent with a young infant.

Collective Unconscious

Martin seems deeply connected with elements of the collective unconscious of the African American community, feeling a burden to uplift the entire community and undo past injustices. He seems to carry the weight of pain born by several generations and views himself as needing to sacrifice himself to make the lives of others better. In this way, the Christian themes of martyrdom are also playing out in his life.

Awareness of Self

Martin is not yet fully aware of Self, but is in the early process of individuation. He is in the second half of his life in which he has a stable career, meaningful marriage, and a growing family, and has begun the process of becoming more aware of certain areas in his life that need to be addressed. There are parts of Martin that are longing to come into consciousness as indicated through his reoccurring dreams and his symptoms of depression that come from his job. Martin, however, is not yet aware of his unconscious feelings and desires.

Shadow

Many of the Shadow parts of Martin are not yet being acknowledged and include his anger toward his wife for becoming pregnant again, feelings of helplessness over his job situation, and the desire to be free from his family and not have the responsibility of being the family provider or role model for society. All of these unacknowledged parts of himself leave Martin depressed and overwhelmed, which lead to the occasional angry outburst at his wife.

Archetypal and Mythical Themes

Hero On multiple levels, Martin's life has been defined by the hero archetype. He has pushed himself very hard to achieve professional success to provide for his family and to overcome negative social stereotypes. Although he enjoys this sense of accomplishment, it has come at the price of denying a sense of freedom and fulfilling personal desires.

Trickster The trickster appears in Martin's dream as the laughing guard who swallows the key to his jail cell. Martin's dream illustrates the trapped feelings that he may feel about his job and with his wife in having another child so late in their adult lives. Even

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though Martin yells back to the guard about his innocence and good nature, it falls on deaf ears, as to indicate that even though Martin is a good person, he is still trapped. The trickster seems to be pointing to the paradox of feeling trapped in a "good" life.

Polarities

Martin is struggling with the conflicting desires within him of responsibility and freedom. On the one hand, Martin is a committed family man who desires to be a good father, husband, and financial provider, and on the other hand, he desires to be free to pursue his own career aspirations and not feel trapped into the role of being a father with a young infant. Martin seems to have difficulty in balancing the two polarities and is instead deeply aligned to his responsible self, without satisfying any need for freedom—therefore causing him to feel depressed.

Complexes

Martin seems to be struggling with themes of heroism and martyrdom that have been taken to such an extreme that he now feels trapped in the "heroic" life he created. Because he is so proud of his accomplishments, it is hard to see how he is trapped by his success. He is even more confused because his unacknowledged desire to have fewer burdens does not fit with the ego identity he has worked so hard to create.

Personality Types

Extraversion versus Intraversion Martin is highly extraverted, as indicated through his passion for being active both socially and professionally. He enjoys interacting with people and has always had a drive to pursue new activities with his career. His extraversion has helped him grow professionally and be promoted to an executive position at his company. However, he now finds himself to be at a standstill in his career, which could be contributing to his overall feelings of depression.

Sensing versus Intuitive Martin experiences the world through his senses. He trusts information that is tangible and concrete. Martin will most likely respond to interventions that can be experienced. Interpretations of Martin's unconscious will need to be backed by evidence if they are going to be meaningful to him.

Thinking versus Feeling Martin organizes information and makes decisions through thinking. He is highly rational and logical, so when making decisions that involve his family, he will often move to the rational side of him, instead of making decisions based on his personal feelings. Therefore, when thinking about the needs of his family versus his personal career aspirations, he will defer to his family's needs first.

Judging versus Perceiving Martin is of the perceiving type in how he deals with the outside world. He prefers the spontaneous parts of his life and enjoys exploring new possibilities, which may be part of why his mundane career has been so difficult for him.

Treatment Plan: Jungian

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration:* [Use professional language when appropriate; ensure he feels respected as African American male. Adapt communication to MBTI type by allowing AM to "think aloud," using concrete examples, offering logical explanations, and allowing for exploration of multiple possibilities.]

(*continued*)

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Relationship building approach:
   a. Create a "**collaborative educator**" relationship in which client views counselor as a resource on personal journey of healing and individuation.

2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Assess multigenerational system; local African American community dynamics; professional community; experiences of marginalization.
   a. **"Confession**" or telling of unedited life story.
   b. Identify prominent conflicts related to **archetypes**, **polarities**, **complexes**, **and shadow elements of self**.
   c. Identify **Myers-Briggs psychological type**.

Initial Phase Client Goals

1. *Decrease* **unconscious conflicts** that escalate to crisis to reduce angry outbursts towards client's wife.
   a. Analysis of **complexes**, **polarities**, **and archetypal patterns** that fuel angry outbursts.
   b. **Active imagination** to increase coping skills and develop alternative responses to crisis.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* Monitor client's response to communication to ensure language is good fit for his professional background, cultural norms, and personality type.
   a. Monitor and analyze **transference**; adapt relationship to accommodate **personality type**.

Working Client Goals

1. *Decrease* **unconscious conflict** and **complexes** related to the client's work and perceived family role to reduce depression.
   a. Analysis of **childhood experiences**, **symbols**, **dreams**, and **archetypes** to bring unconscious conflicts to conscious awareness and allow for catharsis.
   b. Analysis of **synchronicity** of conflict to understand conflicts and identify their role in the individuation process.

2. *Increase* awareness of role of **persona**, **shadow**, and **Self,** as well as the role of the Trickster in the client's life to reduce anxiety.
   a. Analysis of **childhood experiences**, **symbols**, **dreams**, and **archetypes** to bring unconscious archetypal conflicts and shadow elements of self to conscious awareness.
   b. **Sand play** to explore dynamics of persona, shadow, Self, and other archetypes.

3. *Increase* **integration of polarities** in personality and consciousness to reduce depression and anxiety.
   a. Analyze **transference** to identify and integrate polarities.
   b. Analyze **synchronistic** events to facilitate integration of polarities.

Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity consideration:* Explore possibilities to connect with supportive religious and community resources.
   a. Educate client on how to use analysis of **synchronicity**, **dreams**, and **symbols** to independently continue lifelong process of **individuation**.

(*continued*)

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Closing Phase Client Goals

1. *Increase* ability to consistently connect with and act from **Self** to reduce potential for relapse in depression.
   a. Educating client on how to analyze **dreams**, **symbols**, and **synchronistic** events with increasingly less assistance from counselor.
   b. **Active imagination** to consciously transform conflicts and complexes.
   c. Use of personally meaningful symbols to solidify connection with **Self**.
2. *Increase* **sense of connection** to others, humanity, and the divine to reduce potential for relapse in depression.
   a. Educating client on how to increase tolerance of other **personality types** and alternative ways of being in the world.
   b. Use of personally meaningful **symbols** and **synchronicity** to solidify connection with divine.

Questions for Personal Reflection and Class Discussion

1. Do you think about Jung's idea about the collective unconscious? Do you have any personal experience that informs your opinion?
2. Describe an archetypal pattern from your own life. In what ways has it played out in your life?
3. Most people reading this book are influenced by the "healer" archetype. How might this archetype play out in your life? Might it also be related to the martyr archetype?
4. What strengths does this approach have for working with diverse clients? What limitations?
5. Based on the description in the text and/or prior experiences, what do you believe your Myers-Briggs type is?
   a. Which polarity feels like your greatest area of strength?
   b. Which polarity is related to the most struggles in your life?
6. Jungian analysis incorporates many spiritual concepts. Do you think this is a strength or limitation of the approach? Why?
7. What ideas do you have for incorporating spirituality into the counseling process?

Online Resources

Associations

Note: In addition to those listed, most major cities have an association or institute for psychoanalytic studies, and many also have an institute dedicated to the work of C. G. Jung.

American Institute of Psychoanalysis
www.aipnyc.org

American Psychological Association, Division 39, Psychoanalysis
www.apa.org

American Psychoanalytic Association
www.apsa.org

C. G. Jung Institute of Chicago
www.jungchicago.org

C. G. Jung Institute of Los Angeles
www.junginla.org

C. G. Jung Institute of New York and CG Jung Foundation
www.cgjungny.org

Center for Applications of Psychological Types (Myers-Briggs)
www.capt.org

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Chicago Institute for Psychoanalysis
www.chicagoanalysis.org

International Association for Relational Psychoanalysis and Psychotherapy
www.iarpp.org

International Psychoanalytic Association
www.ipa.org.uk

Jungian Society for Scholarly Studies
www.thejungiansociety.org

Los Angeles Institute and Society for Psychoanalytic Studies
www.laisps.org

Myers-Briggs
www.myersbriggs.org

Psychoanalytic Institute of New York
www.psychoanalysis.org

Society of Analytical Psychology
www.jungian-analysis.org

Journals

Contemporary Psychoanalysis

Journal of Analytical Psychology
www.wawhite.org

Journal of the American Psychoanalytic Association
www.jungian-analysis.org/journal-of-analytical-psychology

Psychoanalytic Dialogues
www.apsa.org
www.theanalyticpress.com

Videos

See the Theory in Action Videos at Cengagebrain.com

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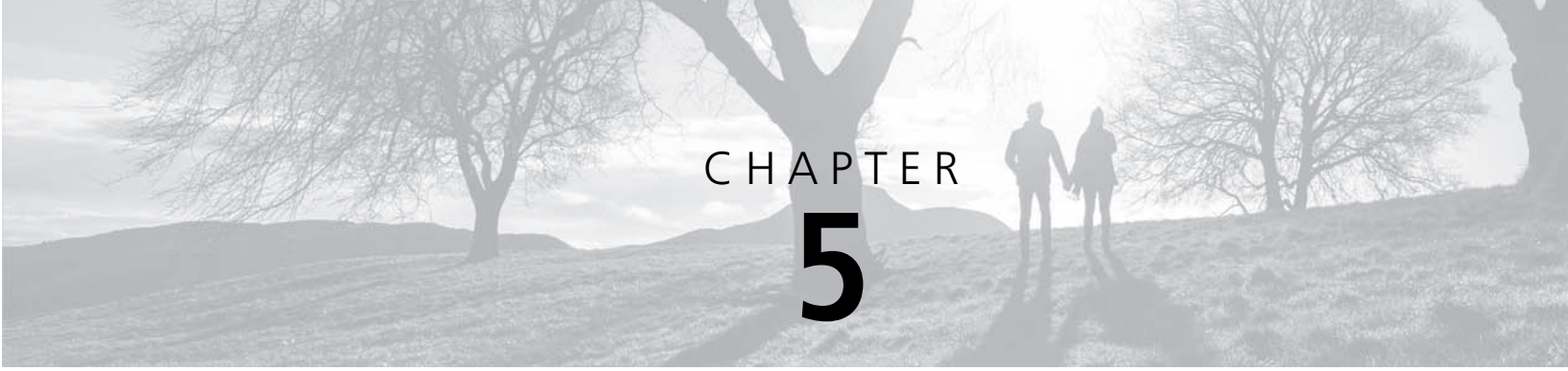

CHAPTER

5

Adlerian Individual Counseling

The chief danger in life is that you may take too many precautions.

—Alfred Adler

And my personal favorite:

The only normal people are the ones you don't know very well.

—Alfred Adler

I first studied Alfred Adler while studying abroad at the University of Salzburg in Austria. In my "Tiefenpsychologie" (depth psychology) course, we covered Freud, Jung, and Adler. I was well acquainted with the first two from my two years of psychology undergraduate course work at the College of William and Mary, but who was Adler? The "Eagle"? Apparently, some guy the Austrians thought played in the same league of Freud and Jung. I was suspicious that Adler was more of a local hero—or one who no longer had much influence. As with most thoughts I had as an undergraduate, I was wrong. Very wrong. It turns out that Adler's ideas lay the groundwork for the majority of theories practiced in the 21st century, and, as many Adlerians lament, his work is rarely cited by later generations—and, apparently, my cognitive-behavioral faculty at William and Mary (Sweeney, 2009). To be fair, the later generations may not have immediately read his work when they developed their theories—and so academics have a lot to bicker about in this regard—but in the big scheme of ideas, Adler was first to put pen to paper and describe many of the counseling principles we find common today. So, I hope you take careful note of his work and look for its quiet influence in the chapters that follow.

Lay of the Land

The unsung hero of counseling and psychotherapy, Alfred Adler's work laid the foundation for most forms of modern counseling. Even when not directly cited, elements of his ideas are identifiable in object relations, self psychology, humanistic, cognitive, behavioral, family systems, feminist, multicultural, and postmodern approaches. His approach has been characterized as an analytic-behavioral-cognitive approach that also incorporates systemic elements (Mosak & Maniacci, 1999). A contemporary of Freud and Jung who also worked at the University of Vienna, Adler developed a unique approach to

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counseling that is quite distinct from the psychoanalysis of Freud. Although modern practitioners have adapted his work for current times (Carlson, Watts, & Maniacci, 2006; Sweeney, 2009), for the most part Adler's individual psychology is practiced using the same key principles and practices identified by Adler in the 1910s. Adler's work has also been applied to group counseling and education (Adler, 1978; Carlson et al., 2006; Sweeney, 2009).

In a Nutshell: The Least You Need to Know

Adler's Individual Psychology departed from his colleagues Freud and Jung on numerous issues, including the following:

- *Holistic view:* Adler posited that a person must be seen *holistically*, as a unified personality or "individual."
- *Social factors:* Also departing from Freud's deterministic view, Adler emphasized that a person's *social environment* was a determining factor influencing personality development.
- *Choice:* He believed people have *choices* in how they approach their lives and that their past does not determine their future.
- *Social motivation:* He believed that people were motivated primarily by social connections, which he called *social interest*, rather than innate instinctual drives; he believed that high levels of social interest and prosocial behavior were signs of psychological health.
- *Teleological and goal oriented:* Adler believed that behavior was *purposeful* and *goal oriented* and that people strive toward meaningful activity, success, and achievement.
- *Subjective and phenomenological:* In addition, unlike Freud, Adler was interested in understanding and valuing a person's *subjective reality*, a principle emphasized in phenomenological approaches (see Chapter 6).

Adlerians believe that in striving for *superiority* and betterment of self, each person develops a *style of life* or *lifestyle*, a characteristic set of attitudes and assumptions that help a person make sense of life. This style of life clearly emerges in the first six years of life, but later development and events also shape a person's lifestyle. A person's style of life is the template through which all life events are interpreted; faulty interpretations and mistaken notions cause problems and difficulties. The process of counseling aims to help people correct these *basic mistakes* or faulty notions, enabling them to *consciously choose* a new style of life (you can now understand why Adler and Freud had bitter disagreements over espresso and strudel at Cafe Landtmann).

The counseling process itself is brief (generally fewer than 20 sessions; Bitter & Nicoll, 2000), present- and future-oriented (with some assessment of the past), and directive (Carlson et al., 2006). The counselor's primary role is *educational*, the counselor helping clients to understand the mistaken beliefs that inform their lifestyle and to help them improve their social relatedness, strive for goals that have meaning, and master the self. Counselors use *encouragement* to help clients move in the direction of their goals. Through a process of understanding *early recollections*, the *family constellation*, *sibling position*, and *style of life*, clients gain insight and self-understanding. Once insight is achieved, counselors help clients to develop the courage to take new action and make new decisions in their life and relationships.

The Juice: Significant Contributions to the Field

If there is one thing you remember from this chapter, it should be …

Social Interest and Community Feeling

Adlerians believe that humans are innately social creatures (modern translation: "genetically wired") (Adler, 1924, 1959; Dreikurs, 1989). As a species, humans need each other

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to survive. *Social interest* or *community feeling* (literal translation of the German *Gemeinschaftsgefühl*) refers to a person subjectively experiencing a sense that he or she has something in common with other people, is a part of a community, and benefits from cooperating with others in the community (Mosak & Maniacci, 1999). Moreover, Dreikurs (1958) emphasized that it is more than just the feeling of belonging: "The ideal expression of social interest is the ability to play the game [of life] with existing demands for cooperation and to help the group to which one belongs in its evolution closer toward a perfect form of social living. This implies progress without creating unnecessary antagonism" (p. 8).

In part, social interest is demonstrated by a willingness to *give more to the community than one receives in return* (i.e., have a generous spirit; Dreikurs, 1989). More important, the draw toward connection is a central organizing value in a well-adjusted person's life. In contrast, those who "measure their happiness and satisfaction only by what they get … pay [for their error] in unhappiness and suffering" (p. 6). Laying the foundation for social justice and multicultural awareness, Dreikurs (in translating Adler's words) acknowledges that "sometimes the interests of various groups conflict. In such perplexing situations the social interest causes us to see that the interests of the super-ordinate group, which are justified on the ground of objective needs, have the first claim on us. We certainly want to do what we can to help men to found a society embracing the whole human race" (p. 8).

Adler identified three primary areas of social life in which social interest plays a central role: (a) communal life, (b) work, and (c) love relationships (Ansbacher & Ansbacher, 1956) and maintained that a person must be successful in all three areas to be well adjusted. Modern Adlerians have added three other areas: (d) self-acceptance, (e) spirituality, and (f) parenting (Carlson et al., 2006; Dreikurs & Mosak, 1967; Mosak & Dreikurs, 1967; Sweeney, 2009). Healthy adaptation within each of these realms involves striving for the goal of *perfection* (in a positive sense), becoming one's best self in each of these realms. In contrast, those who are more poorly adjusted strive for the goal of *personal superiority*, trying to be better than others, a critical distinction in Adlerian theory.

Adler explains that a sense of *individual inferiority* impairs a person's social interest. *Individual inferiority* is one of three forms of inferiority posited by Adler (Dreikurs, 1989):

1. *Biological inferiority:* Based on the need to form groups for physical survival; this form of inferiority promotes social interest.
2. *Cosmic inferiority:* Recognizing the inevitable death and the limitations of human existence; this form of inferiority also promotes social interest.
3. *Personal inferiority:* Feeling less powerful, able, or valued than others; this form of inferiority *inhibits* social interest because one does not feel as if he or she belongs to the community.

This sense of personal inferiority is the source of clients' presenting problem: "any person who labors under a sense of inferiority always tries to obtain power of some kind in order to cancel the supposed superiority of other people. His feeling of inferiority impels him to strive for significance" (Dreikurs, 1989, p. 22); when this becomes a pattern, it is called an *inferiority complex*, a term that has trickled into popular vernacular (Mosak & Maniacci, 1999).

People respond to inferiority in primarily two ways: (a) to gain significance by achievement or (b) to avoid obligation, risky decisions, and connection with others. The pursuit of outstanding achievement can contribute to society even if fueled by fear; however, people who are ruthless and unethical in these pursuits waste their lives on what Adler terms "the useless side of life" (Dreikurs, 1989, p. 24). The counselor's role is to encourage people to transform their sense of inferiority to more effectively promote their social interest and eventually to reduce their overall sense of inferiority.

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Assessing for Social Interest

When assessing for social interest, Adlerian counselors listen carefully to how clients describe their lives and problems. The three general types of social interest are as follows (Sweeney, 2009):

	Organizing Question	*Content of Conversation*
High Social Interest	*What* am I doing?	Sharing, enjoying, creating
Low Social Interest: "Successful person"	*How* am I doing?	Power, position, possessions
Low Social Interest: "Failure"	*How* am I doing?	Complaining, blaming, fears, excuses

Rumor Has It: The People and Their Stories

Founding Figures

Alfred Adler Born in Vienna, Austria, in 1870 to a Jewish merchant family, Alfred Adler's early years were difficult: he had rickets, nearly died of pneumonia, and was run over by two vehicles. He was an average student who was competitive with his older brother (Alfred was the second oldest of six children; this is an important side note, as his theory emphasizes the importance of birth order; Carlson et al., 2006; Sweeney, 2009). After receiving his medical degree, he practiced as a general physician and ophthalmologist in Vienna near the Prater, the central amusement park. His patients included many of the Prater's circus workers, and this most likely enabled him to learn to appreciate unusual strengths in people. During this time, he met Raissa, who was a Russian socialist and activist who was studying in Vienna; they then married and had four children.

In 1902, Freud invited Adler to join Freud's informal discussion group with other leading psychiatrists. This group, the Wednesday Society (German *Mittwochsgesellschaft*), became the beginning of the psychoanalytic movement. Most biographers agree that Adler's ideas differed from Freud's from the beginning. After serving as president of the Vienna Psychoanalytic Society, Adler and a group of his supporters left in 1911, the first to leave from Freud's group. Most scholars agree that Adler was never Freud's pupil; rather, they were early colleagues (Sweeney, 2009) initially sharing similarities as they developed a new form of treatment: "talk therapy." Their mutual dislike was well documented and is not surprising given their radically different approaches to psychotherapy; nonetheless, Adler respected Freud for his contributions, most notably his work on dream interpretation. The fundamental difference (which is major) between their two theories is that Adler believed that the *social realm* was as important as the *inner world*, while Freud concerned himself only with the latter.

In 1912, Adler founded the Society for Individual Psychology and lectured internationally for 25 years promoting his socially oriented approach. In the 1920s, he established numerous child guidance clinics, which were later closed because of his Jewish heritage. In the 1930s, as World War II approached, he accepted an appointment at the Long Island College of Medicine in New York. He died in 1937 of a heart attack during a lecture tour.

Rudolf Dreikurs Born in Vienna in 1897 and a student of Alfred Adler, Dreikurs (1958, 1989; Dreikurs & Loren, 1968; Manaster & Corsini, 1982) continued promoting individual psychology after Adler's death and is credited as the principal person who promoted Adler's work in the United States. In particular, Dreikurs communicated Adler's ideas in pragmatic terms, making them useful to the average practitioner. Dreikurs specialized in working with preadolescent children, promoting cooperative behavior without

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punishment or reward (i.e., behavioral interventions). He was a significant force in the development of child guidance centers. In addition, he also used individual psychology principles to improve children's learning in the classroom (Dreikurs, 1968).

Modern Practitioners

Heinz and Rowena Ansbacher Heinz and Rowena Ansbacher have collected and edited many of Adler's original writings for English audiences (Ansbacher & Ansbacher, 1956, 1964). Their work preserves and explicates Adler's original writings and helps translate and clarify them for everyday practice.

James Bitter James Bitter is an influential Adlerian counselor who has developed Adlerian counseling as a brief approach and family approach (Bitter, Christensen, Hawes, & Nicoll, 1998; Bitter & Nicoll, 2000).

Jon Carlson Jon Carlson has developed Adlerian counseling for couples, families, and diverse populations (Carlson et al., 2006). He is also the host for several video training series, including the *APA Psychotherapy Video Tape Series III*, *Brief Therapy Inside and Out*, *Family Therapy with the Experts*, and *Psychotherapy with the Exper*ts (Carlson, n.d.).

Don Dinkmeyer, Gary McKay, and Joyce McKay Don Dinkmeyer, Gary McKay, and Joyce McKay (Dinkmeyer, McKay, & McKay, 2007) developed the *Systematic Parenting for Effective Parenting (STEP) Program*, an evidence-based parenting program based on Adlerian principles.

Harold Mosak Harold Mosak has written numerous primers and texts that offer practical descriptions of how to use Adler's approach in modern contexts (Mosak & Di Pietro, 2006; Mosak & Dreikurs, 1967; Mosak & Maniacci, 1999; Mosak & Sculman, 1988).

Thomas Sweeney Sweeney (2009) has developed a modern Adlerian approach that integrates elements of positive psychology and includes applications for career, couple, family, and group counseling.

Big Picture: Overview of Counseling Process

Adlerian counseling involves four stages (Sweeney, 2009):

- *Phase 1:* Establish an egalitarian relationship
- *Phase 2:* Assess lifestyle and private logic
- *Phase 3:* Encourage insight and self-understanding
- *Phase 4:* Educate and reorientate

Phase 1: Establish an Egalitarian Relationship

The first phase, described in detail in the "Making Connection" section, involves making a positive, warm connection with clients in which the counselor focuses on strengths and abilities. Adlerian counselors have the utmost hope that every person can find better ways of coping, improve their sense of belonging, and become meaningful contributors to the community.

Phase 2: Assess Style of Life and Private Logic

In the second phase, counselors assess clients' style of life and private logic, which is described in detail in the "Viewing: Case Conceptualization" section. Typically, the assessment period involves reviewing the following:

- Level of social interest
- Style of life and private logic

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- The family constellation and sibling position
- Early recollections
- *Diagnostic and Statistical Manual of Mental Disorders (DSM)* diagnosis

Phase 3: Encourage Insight and Self-Understanding

In the third phase, counselors help clients gain better self-understanding, promoting *insight*, albeit a different form of insight than is typical in psychoanalytic approaches. In Adlerian work, counselors use insight as an *impetus* and source of positive motivation to take action and make changes rather than being an end in itself. In this phase, the counselor offers possible *interpretations* of behavior by identifying underlying motivations for problems, such as feelings of inferiority motivating a person's avoidance of commitment in a love relationship. Unlike Freudian interpretation, Adlerians *collaboratively* work with clients to find useful, meaningful interpretations of client motivations rather than relying on the counselor's objective perspective to determine the correct interpretation.

Phase 4: Educate and Reorientate

The final phase involves taking action! Counselors challenge clients to develop the *courage* it takes to make life changes based on their insights. These changes in behavior are referred to as a *reorientation*, referring to the fact that a person must "reorient" to life by correcting *basic mistakes* in his or her *style of life*. This phase involves primarily motivating the client to take action based on education regarding more accurate and effective approaches to life.

Making Connection: Counseling Relationship

Egalitarian

> The psychotherapist must lose all thought of himself and all sensitiveness about his ascendancy, and must never demand anything of the patient. … The patient's social interest, which is always present in some degree, finds its best possible expression in the relation with the psychologist. The consultee must under all circumstances get the conviction that in relation to the treatment he is absolutely free. He can do, or not do, as he pleases. (Ansbacher & Ansbacher, 1964, p. 341; translation of Adler's 1933 article "Sinn des Lebens, What Life Should Mean to You")

A radical position during a time when psychoanalysis dominated the field, Adler promoted *egalitarian* relationships with clients that allowed them to maintain a sense of agency and choice (Sweeney, 2009). Counselors should not see themselves as superior even though they are in a helping position. Instead, Adlerian counselors—who do offer interpretations and education—approach clients from a more humble position of having something of potential usefulness for clients, understanding that what is offered may or may not be actually useful in the client's subjective world.

Encouragement

One of its most distinguishing elements, "the Adlerian approach is characterized by its deliberate efforts to encourage the patient" (Dreikurs, 1989, p. 88). However, Adlerian encouragement should not be confused with a Pollyanna, cheerleaderish, "just-do-it" form of encouragement. Instead, Adlerian encouragement comes from a philosophical presupposition that life problems are not the result of personal failure or innate character flaws, as it may seem to a person experiencing a sense of *personal inferiority*; rather, they are the result of mistaken beliefs about life (a position also adopted in cognitive counseling). Thus, Adlerians are optimistic and hopeful about helping clients resolve their problems and thus believe beyond a shadow of a doubt that clients can improve their lives and therefore encourage them to do so.

Described as "a friendly, jovial, concerned person, filled with common sense, an ideal 'uncle'" (Manaster & Corsini, 1982, p. 168), Adler's style of encouraging fuses warmth, honesty, and practicality. To effectively convey encouragement, counselors must do it both verbally and nonverbally, which includes smiling, listening attentively, being patient, and taking action when needed (Sweeney, 2009). In the case study at

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the end of this chapter, the counselor uses encouragement extensively to help Budi, an Indonesian immigrant who became disabled because of a rare neural disorder.

Strategies for Conveying Encouragement

- Curiously asking about unique hobbies, abilities, or interests: "Tell me more about how you learned to do X."
- Verbally saying, "This is something I believe you can do."
- Complimenting and commenting on existing coping abilities: "You have done a remarkable job thus far raising two children without a partner."
- Hopeful comments when discussing new behaviors: "Doing X [new action—such as going to social events] is going to be far easier than what you have been doing to simply limp along all these years fearing failure."
- Correcting mistaken impressions in a hopeful way: "You may *feel* inferior, but it doesn't seem like your fears are based on a realistic assessment of your abilities."

Empathy and Social Interest

Counselors should be role models for social interest. As defined by Adler, social interest inherently requires empathy. Adler refers to an "English author" (this was before the *APA Manual of Style* requirements for direct quotation; he would have lost points on his paper for this glaring omission) who provides the best definition of social interest and social feeling that he could find at that time: "To see with the eyes of another, to hear with the ears of another, to feel with the heart of another" (Ansbacher & Ansbacher, 1956, p. 135). Carlson et al. (2006) liken this quality of social interest on the part of the counselor to Carl Rogers's empathy (see Chapter 6). Similarly, Carlson et al. (2006) link Adler's concept of encouragement to Rogers's core condition of unconditional positive regard, because both approaches share a fundamental assumption: valuing clients for their humanity.

Directive

The final aspect of the counseling relationship initially seems at odds with the preceding three. Adlerian counselors are directive (Carlson et al., 2006). How can a counselor be egalitarian and at the same time directive? The catch is that their directiveness comes in the form of *education*: providing practical and helpful information. The key is a teaching style that is "encouraging" and nonhierarchical. The underlying message is that "I am offering you some information I believe to be useful; you can take it or leave it." Thus, they are not pushy salespeople. They educate with enthusiasm and hope, and thus their clients are generally willing pupils.

The Viewing: Case Conceptualization

Lifestyle Assessment

Lifestyle assessment is the heart of Adlerian assessment. *Style of life* or *style of living* is perhaps the closest modern translation of Adler's original German term *Lebensstil*. Lifestyle has been defined as *how* a person characteristically responds to others and the environment (Manaster & Corsini, 1982). Mosak and Maniacci (1999) define lifestyle as "the individual's characteristic way of thinking, seeing, and feeling towards life and is synonymous with what other theorists call 'personality'" (p. 31).

Adler thought of lifestyle as *the individuality of person expressing itself in its social environment* (Ansbacher & Ansbacher, 1956). Adler uses a pine tree as a simile for understanding the development of lifestyles: a pine that lives in the protection of a valley expresses itself quite differently from one growing on a mountaintop, even though they have the same genetics. So, too, humans express their individuality differently, depending on their social environment. Unlike the pine tree, humans have more choice in how they

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choose to express themselves: our mobility gives us a "leg up" on those trees (how could I resist such a pun?).

Adler used style of life liberally and variously to refer to the self, personality, unity of the personality, individuality, method of facing problems, opinion of self, view of life problems, and general attitude toward life (Ansbacher & Ansbacher, 1956). So, if it seems like the term is a bit general and all-encompassing, you're catching on. Most commonly in modern Adlerian counseling, a person's style of living refers to his or her fundamental beliefs about what is valuable in life, what is ideal, and what is to be avoided. Adler cautions that a person's style of living is not immediately apparent: "As long as a person is in a favorable situation, we cannot see his style of life clearly. In new situations, however, where he is confronted with difficulties, his style of life appears clearly and distinctly" (Ansbacher & Ansbacher, 1956, p. 173). Adler believed that a person's style of life becomes fixed by age 5, and general research on personality development supports this claim (Manaster & Corsini, 1982).

Both Sweeney (2009) and Carlson et al. (2006) have developed contemporary approaches to lifestyle assessment. Typically, the following areas are assessed:

- Parenting style
- Family constellation and birth order
- Early recollections
- Basic mistakes
- Organ inferiority or physical weak points
- "The question": function of the symptom
- Dreams

Parenting Style

Adler was particularly concerned about two parenting styles: pampering and neglect, with the former having more detrimental effects than the latter (Mosak & Maniacci, 1999). His concern with pampered children was that they are accustomed to "getting" and demand whatever they want and thus develop low levels of social interest and do not thrive as adults. In contrast, a neglected child may suffer but is more likely to develop social interests and to pursue self-improvement. However, he noted that children were not passive recipients; rather, children and parents mutually shaped each others' behavior. Adler believed that it was the child's *subjective* perception of the parenting style that ultimately most affected a person's style of life.

Questions for Assessing Parenting Style

- Describe your relationship to your parents as a child. Were they indulgent? Strict? Inconsistent? Supportive?
- How did you get what you needed? How did you get what you wanted?
- Did you have favorite strategies for getting your way?
- Which child was able to influence your parents the most? The least?

Try It Yourself

Either alone on paper or in a role-play with a partner, try answering these questions to assess parenting style.

Family Constellation and Birth Order

As alluded to in "Rumor Has It" above, Adler put considerable emphasis on the sociopsychological configuration or *constellation* of a person's family, with an emphasis on birth order (Sweeney, 2009). Adlerians believe that the sibling closest in age and *most different* is the sibling that most affects how one defines the self. Above all, it is a

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person's *subjective* interpretation of the family constellation that has lasting impact on the style of life.

Debated for over 134 years, little consensus has emerged on the effect of birth order on personality (Hartshorne, Salem-Hartshorne, & Hartshorne, 2009). Adler considered birth order an important—but not determining (remember, it was Freud who believed in determinism)—variable in understanding human behavior (Sweeney, 2009). However, research over the years has yielded no definitive answer as to whether and how birth order affects development, in part because many past studies did not control for socioeconomic status and ethnicity, both of which are frequently correlated with larger family size (Hartshorne et al., 2009; Sweeney, 2009). However, better-controlled research continues on birth order. For example, a recent study supports the idea that people are more likely to form close friends and romantic relationships with persons of the same birth order (Hartshorne et al., 2009).

- *Oldest child:* The oldest child generally begins life as the center of attention and typically learns to take the "newcomers" in stride if the parents provide encouragement for them to recognize their place in the family structure (Sweeney, 2009). Oldest children tend to relate well with adults, assume social responsibility, and develop socially appropriate forms of coping. Their lifestyle often includes striving for superiority, which may be a problem if not moderated over time.
- *Second child:* Second children will typically pursue an opposite position than the first because that is the role most readily available to them. On average, they may be less responsible, more independent, or more demanding than their older sibling. In some cases, the second child strives to be number one, creating *sibling rivalry*, especially if parents do not discourage the competition and comparisons. Some give up in discouragement, while others are socially productive even though they are motivated by the mistaken belief that their value comes from their achievements.
- *Middle child:* Families of three or more have middle children, who may feel "squeezed" between the others. Being neither the first nor the youngest child, many feel like they do not have a clear or unique role to play in the family. Similar to second children, middle children generally tend to define themselves in the opposite direction of their older sibling(s). They may be more independent, sensitive, or even rebellious, and some may directly ask parents for reassurance of their love. A benefit of their position, many learn to be skilled mediators, cope well with social stress, and learn from the mistakes of others (namely, their older siblings)—often with minimal gloating or name-calling.
- *Youngest child:* Perhaps the most frequently referred to family role, the "baby of the family" tends to enjoy being the center of attention and indulgence given that there are so many people in the family to take care of their needs. Youngest children often grow up to be charming or even manipulative and often avidly seek life's pleasures. If the parents emphasize achievement, they may become the hardest working of all to prove their place and ultimate worth.
- *Only child:* Only children are much like older children except that they are never dethroned and generally do not have the pressure of a close competitor. Only children tend to be inducted into the adult world early, becoming responsible, cooperative, and mature for their age. However, many have difficult relating to their peers, especially in the area of sharing.

To assess for birth order, counselors shouldn't simply ask, Were you the oldest or youngest in your family? Meaningful assessment requires more follow-up than that.

Questions for Assessing Birth Order and Family Constellation

- Do you have any siblings? If so, who was oldest, second oldest, and so on?
- Can you describe the role of each child in the family? How did your parents encourage or discourage these roles?

(*continued*)

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- Describe your parents' relationship as a couple and as a co-parenting team.
- Who was most like your mother/father? Which siblings were most similar/dissimilar?
- Were there "favorites" or "teams"? Did the roles change over the years?
- Do you remember your attitude toward your siblings at various points in your childhood: preschool, school age, high school, and adulthood?
- What are the favorite family stories, sayings, or nicknames around sibling rivalry and differences?
- What do you think you learned from your role in the family?

Early Recollections

Adler used early childhood recollections as a means for understanding a person's style of life (Ansbacher & Ansbacher, 1956). *Early recollections* refer to a person's earliest clear memories of an event or situation. Often these reveal the source of fundamental beliefs about one's values, others, or life more generally. They tend to be definitive moments that often play a mythic role in a person's life: feeling left out at the playground, picking apples with your mother, or going for a car ride with dad. Generally, a minimum of three memories is required to identify a pattern. However, depending on the complexity of themes, more may be necessary to get to obtain a clearer understanding of how various elements of the lifestyle were developed.

Questions for Assessing Earliest Recollections

- "When you think back over your childhood, what are your earliest memories (generally before the age of 7)?" *or* "Describe what you believe to be your earliest memory from when you were a child, perhaps before you entered school or in preschool."
- "What were you feeling at that time? What were others feeling?"
- "What did you understand or not understand about what was going on? What were others thinking?"
- "What is the most vivid part of the memory? Why do you think that stands out?"
- "What do you think you learned from this experience?"

Basic Mistakes

Basic mistakes are faulty assumptions that develop in childhood as children make sense of their experiences, such as loneliness, parental anger, disappointment, traumas, and loss. To some extent, everyone enters adulthood with mistaken notions. However, when basic mistakes lead to a sense of *inferiority* and *low social interest*, a person is more likely to develop symptoms and end up in a counselor's office. Adler noted that in these situations, "the apperception-schema of the patient evaluates all impressions as if they were fundamental matters and dichotomizes them in a purposeful manner into above-below, victor-vanquished, masculine-feminine, nothing-everything, etc." (Ansbacher & Ansbacher, 1956, p. 333). In simpler terms, basic mistakes involve seeing life in either-or, black-and-white terms in which one side is valued as "better" than the other. As you can imagine, this quickly leads to feelings of inferiority on multiple fronts.

Mosak and Maniacci (1999) elaborate on this by identifying five types of basic mistakes:

1. *Overgeneralizations:* People who overgeneralize tend to exaggerate contextual truths into global all-or-nothing truths (e.g., "my boyfriend cheated on me" gets translated into "men can't be trusted").
2. *False or impossible goals of security:* Some people try to find ways to remove all risk from life, often making unreasonable demands on others (e.g., "If you love me, you

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will never hurt me"—even unintentionally—a great romantic ideal but difficult to achieve if flesh-and-blood humans are involved. Virtual realities may eventually hold different possibilities).

3. *Misperceptions of life and life's demands:* Some basic mistakes boil down to not really understanding the inescapable rules of life: people die, survival takes effort, survival requires cooperation, kindness matters, laws of nature apply evenly, hurting another ultimately hurts you, life doesn't come with guarantees, and so on (e.g., "I want to fall in love with someone who I know won't hurt me": again, a Labrador retriever may be your best option).
4. *Minimization or denial of one's basic worth:* In other cases, a person has gladly owned their sense of personal inferiority and deny their own intrinsic worth (e.g., "Why would anyone want to love me? I am inherently flawed").
5. *Faulty values:* Alternatively, some people cope with life by identifying with faulty values, values that are not in line with social interest but instead self-promotion (e.g., "If I am successful enough and achieve enough, people will *have to* love me").

Assessing a person's basic mistakes is tricky in that there isn't a simple set of questions to ask. The counselor must tease it out by asking about the family constellation, early recollections, and current problems. However, a careful and thoughtful initial assessment process with an eye toward identifying basic mistakes generally makes this process far easier.

Organ Inferiority or Physical Weak Points

Odd to the modern English ear, *organ inferiority* is the term used by Adler to refer to physical weak points in the body. They are the physical parallel to the basic mistake: "what organ inferiorities are to the body, basic mistakes are to the mind" (Carlson et al., 2006, p. 90). Either actual physical problems or the belief that one is physically inferior can have significant impacts on one's style of life. When Adler used the term, he typically referred to children who were blind, had physical deformities, or had chronic illnesses that characterized the turn of the 20th century. In modern contexts, these physical issues often include a person's perception of weight, looks, or athletic ability in comparison to peers—or, in the case of most young American women, airbrushed supermodels.

Dream Analysis

Like Freud, Adler believed that dream analysis provided insight into a client's inner processes; however, unlike Freud, he didn't believe that they were related to infantile sexual wishes (Ansbacher & Ansbacher, 1956). Instead, he used the themes of dreams as clues to help analyze a client's style of life and to help identify potential solutions to problems. Furthermore, Adler believed that *the meaning of a dream was specific to the dreamer* and that the counselor was not in the position to have the final determination of their interpretation. For example, people who have dreams with themes of being hampered by obstacles, being unable to reach destinations, or being unable to meet up with an important person will likely have similar themes of feeling that the *world* (not their choices or actions) is keeping them from achieving their goals.

"The Question": Purpose of Symptom

Saving the best for last, "*the question*" is used to assess the underlying purpose and need for the symptom (Ansbacher & Ansbacher, 1964; Carlson et al., 2006). The question is as follows:

> "What would be different in your life if you didn't have this problem?" (Carlson et al., 2006, p. 110)

The client's response often provides clues as to what is being avoided by having the symptoms. For example, one depressed person may say that he would be more successful at work, while another may state that she would "be the old self" again who used to spend time with friends. The first response belies insecurities in his ability to succeed at work,

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and in the second she may fear that enjoying herself apart from her family reflects on her poorly as a mother and wife. More recently, solution-based counselors use the *miracle question*, which is a variation of Adler's original question (see Chapter 12). In the case study at the end of this chapter, the counselor uses "the question" to assess the purpose of Budi's depression, which he has experienced in various forms over the years.

Psychodynamic Formulation

When assessing a person's style of life, Adlerians also consider basic psychodynamic formulation in the function of symptom (Carlson et al., 2006). They use three general categories for clients in their psychodynamic formulation: neurosis (emotional disturbance expressed through physical or mental disturbance; behavior is generally within social norms), psychosis (loss of contact with reality), or personality disorder (chronic behavioral pattern that significantly impedes relationships). Adlerians use the basic guidelines for understanding the client's style of life.

Type of Person	Response to Challenge:
Encouraged person	"Can-do" attitude. Able to take needed action without worrying about what others think.
Persons with neurotic symptoms	"Yes-but" attitude: "I would take action if I didn't have this problem." They use their symptoms to get away with doing what they want (avoiding social interest) while still receiving social approval ("my symptom is the problem").
Persons with psychotic symptoms	Escapist attitude. They live in fantasy rather than reality to escape life's demands. They say "no" to society's demands.
Persons with personality disorders	"My-way-or-the-highway" attitude. They try to convince others that their way is the right way regardless of what others want or evidence to the contrary: "I'll cooperate if we use my rules."

Life Tasks and Social Interest

Adlerian assessment also involves identifying a person's level of social interest in the six life tasks (Ansbacher & Ansbacher, 1956; Carlson et al., 2006; Dreikurs & Mosak, 1967; Mosak & Dreikurs, 1967; Sweeney, 2009):

- *Work:* Not limited to gainful employment, "work" refers to a person's primary means of being a contributing member of society and can include education, household chores, child care, homemaking, and volunteer activities.
- *Communal life and friendship:* Connecting socially with others and enjoying connections with others is an important life task and measure of a person's social interest.
- *Love relationships:* Perhaps the most challenging of all, love relationships require courage and the greatest level of social interest to sustain.
- *Self-acceptance:* A modern addition that is implied in Adler's original work; developing an accepting relationship of the self as well as self-awareness is foundational to successful relating to others.
- *Spirituality:* More recently, Adlerians have added developing a relationship to something greater than the self as a critical life task.
- *Parenting:* Although not applicable to everyone, parenting requires a particular set of social skills and functioning that should be assessed separately from others.

A balanced life involves active and successful involvement in all these areas of life. Thus, in assessment, counselors should identify the areas in which a person functions best and areas where there are the most problems. In treatment planning, specific goals should be

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written for each area. Manaster and Corsini (1982) have their clients rate the percentage of happiness in each area before and after counseling to measure progress.

DSM Diagnosis

Adler did not use diagnostic classification for the treatment of individuals (Ansbacher & Ansbacher, 1956). However, true to their principle of social interest, contemporary Adlerians have chosen a proactive approach to *DSM* diagnosis because it enables them to better communicate with other professionals who use this language (Sweeney, 2009). Numerous differences exist between the *DSM* approach and Adlerian theory (Carlson et al., 2006; Sweeney, 2009):

	DSM	Adlerian
Approach to pathology	Descriptive: Identifies symptoms	Explanatory: Explains causation
Language	Pathology and deficit-based	Encouraging; positive
Focus	External, measurable behaviors	Subjective experiences

Maniacci (2002, p. 360) proposes a unique approach to integrating Adlerian practice using the multi-axial diagnosis system used in the *DSM-III and DSM-IV* (APA, 2000). Although the DSM-5 (APA, 2013), no longer uses this multi-axial system, the comparison to Adlerian work can still be practically useful:

Axis I: The arrangement (how the client has "arranged" symptoms to cope; corresponds to clinical syndromes and areas of clinical focus)

Axis II: The lifestyle (corresponds to personality disorders and personality features)

Axis III: Organ inferiority/organ jargon (corresponds to physical disorders relevant to psychological treatment)

Axis IV: The shock (corresponds to psychosocial stressors)

Axis V: A *barometer of life tasks* (corresponds to 100-point scale for global assessment of functioning)

Let's break this down step by step. Adlerians would start by focusing on Axis II, which corresponds to a person's style of life. However, this does not mean that they believe that everyone has a personality disorder, nor does it imply that they frequently use these diagnosis codes. Instead, they look at a person's style of life that involves pervasive, patterned responses to life much like the personality "features" that can be listed on Axis II (American Psychiatric Association, 2000). In conjunction with Axis II, Adlerians consider Axis III, physical disorders (i.e., organ inferiority) or physical expressions (i.e., organ jargon) that are related to the client's style of life. For example, a child who felt singled out as a child for not having good athletic ability may carry this sense of being ostracized or humiliated into adult areas of life, such as work and love relationships. Axis IV refers to the "shock" or challenge (i.e., such as a job loss, divorce, or breakup) that overwhelmed the client's coping mechanisms, triggering the symptoms and syndromes used on Axis I to somehow manage feelings of inferiority (i.e., depression, anxiety, or overeating). Axis V records the overall impact on the person's functioning. Although a bit awkward at first, this template provides a useful way to translate and integrate between the *DSM* and Adlerian theory.

Targeting Change: Goal Setting

Long-Term Goal: The Courage to Develop Social Interest

Adler defined *normal adjustment* as having "enough energy and courage to meet the problems and difficulties of life as they come along" (Ansbacher & Ansbacher, 1956, p. 154).

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Life difficulties can occur within any of the six life tasks: work, love, friendship, spirituality, self-acceptance, or parenting. Greater levels of social interest improve functioning in each of these areas (Dreikurs, 1989). Thus, Adlerian counseling requires clients to develop the *courage* they need to face their insecurities and go to the places and do the things that they fear most; the counselor's role is to encourage clients to take the risks needed to develop the social interest needed to fulfill their life tasks.

Wellness, Positive Psychology, and Social Interest

Modern Adlerians have explored the links between social interest and positive psychology wellness research (Carlson et al., 2006; Leak & Leak, 2006; Myers, 2009). Both Adlerian theory and positive psychology emphasize building on and developing strengths (rather than remedying weaknesses) as the preferred approach to addressing strengths. In addition, both approaches set long-term goals of *wellness* as opposed to health, wellness referring to a state of physical, emotional, and social well-being that is achieved through conscious effort, and health referring to a more neutral state in which one is not ill and does not require effort (Myers, 2009). The Adlerian primary goal of developing social interest correlates with the findings of positive psychologists that social connection, altruism, empathy, and social consciousness are highly correlated with happiness (Leak & Leak, 2006). Similarly, Adlerian theory's emphasis on developing social interest within the six life tasks aligns with positive psychology research that emphasizes that meaningful relationships, satisfying work, self-acceptance, and spirituality are all strongly linked to life satisfaction (Myers, 2009). Thus, when setting goals, Adlerian counselors can also draw on a wellness perspective that emphasizes personal choices and positive actions leading to a sense of sustainable wellness; simply reducing symptom frequency is only a first step in achieving this long-term goal. Furthermore, like Adlerian counseling, wellness counseling involves psychoeducation in positive psychology and the correlates of happiness.

Developing Adlerian Goal Statements

General Principles Adlerian theory provides clear guidelines for how to develop early, working, and closing phase goals.

- *Early phase goals:* Address initial crisis symptoms.
- *Working phase goals:* Reduce symptoms related to presenting problem; increase social interest and functioning in life tasks most closely related to the problem.
- *Closing phase goals:* Increase social interest and functioning in other key areas of functioning.

Examples of Early and Working Phase Goals Early and middle phase goals aim to reduce insecurities and basic mistakes that are fueling the presenting problem(s):

- Reduce insecurities that lead to depressive thinking.
- Reduce insecurities that fuel jealousy in relationship.
- Reduce insecurities that lead to underfunctioning at work.
- Develop more realistic expectations of performance at work.
- Reduce the tendency to overgeneralize that leads to arguments with spouse.
- Increase ability to take risks in relationship to increase sense of intimacy.
- Reduce tendency to calculate self-worth based on work performance.

Examples of Closing Phase Goals Late phase goals aim to take the client beyond basic health (lack of symptoms) and toward developing habits of living that promote wellness and social interest in all six areas of functioning: work, friendship, love, self-acceptance, spirituality, and parenting:

- Increase intimacy and connection with family of origin.
- Increase sense of connection with friends and local community.
- Increase sense of connection to divine by reconnecting with spiritual practice.
- Increase self-acceptance related to sexual orientation.

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- Increase emotional connection and redefine relationships with adult children.
- Take steps to pursue line of work (or volunteering) that is personally satisfying.

The Doing: Interventions

Psychoeducation and Task Setting

Perhaps their predominant type of intervention, Adlerians use psychoeducation in all phases of counseling (Carlson et al., 2006). Psychoeducation involves providing clients with psychological information that they can use to change their thoughts, feelings, and/or behaviors. For psychoeducation to be practically useful, counselors need to follow up by setting up specific tasks based on the new information (Sweeney, 2009). In the case study at the end of this chapter, the counselor uses psychoeducation to help Budi understand his diagnosis of depression, the psychological impact of being diagnosed with a disabling condition, and how his role as eldest son in his family has affected his relationship with others.

Phase 1 Topics for Psychoeducation: Establish an Egalitarian Relationship

- Describing client's role and rights in the counseling process, including when setting goals and deciding what to discuss.
- Explaining how Adlerian counseling can address the presenting problem and how it works.
- Defining social interest and its role in the client's problem.

Phase 2 for Psychoeducation: Assess Lifestyle and Private Logic

- Providing a rationale for the assessment process.
- Defining lifestyle and describing how private logic develops and how it is related to the presenting problem.

Phase 3 for Psychoeducation: Encourage Insight and Self-Understanding

- Offering information and research results that counter the inaccurate and/or unrealistic private logic that fuels the problem.
- Providing an explanation of the style of life psychological processes based on Adlerian theory.

Phase 4 for Psychoeducation: Education and Reorientation

- Providing convincing research and theoretically based information to motivate clients to take new action related to a specific problem.
- Offer specific instructions on how to best approach changing behaviors or habits of thought.

Tips for Effectively Providing Psychoeducation and Task Setting

- *Practice!* Yes, I'm serious. There aren't too many counseling or psychotherapeutic skills I recommend that new counselors "practice" on family and friends, but psychoeducation is the major exception. Try explaining concepts and research outcome to people who haven't read books like this one. Notice the types of questions they ask after you explain a concept. That will help you learn what you might be leaving out, what type of jargon needs defining, and what people actually find useful.
- *Ask first:* Perhaps the single greatest secret to making psychoeducation work is *timing:* providing information when the client is in a receptive state. How do you know when they are ready? Ask them, "Would you be open to learning more about X?" If you fail to ask, you risk disrupting the otherwise collaborative relationship.
- *Keep it very, very brief:* During a 50-minute session, I recommend keeping total psychoeducation time to one to two minutes—that's the max. Any other brilliant

(*continued*)

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information you have to share should be saved for the following week because most clients cannot meaningfully integrate and act on more than this. This is one situation where extroversion becomes an Achilles heel; so when you launch into a psychoeducational speech—stop yourself ASAP.

- *Make one point—and one point only:* Try to teach only one concept, point, or skill in a session—the role of social interest, for example. Anything else is too much to be *practically* useful.
- *Ensuring understanding and acceptance:* After briefly providing information, *directly ask* if clients understand and if they believe it is useful and realistic for their life.
- *Apply it immediately:* After you provide information, immediately identify how it can be practically applied in the client's life to address a problem that occurred in the past week or upcoming week.
- *Step-by-step tasks:* After offering two minutes of psychoeducation, the following 48 minutes involve step-by-step instructions on how to apply the information to solve a current problem. Get specific: who does what, when, where, and how often.
- *Follow up:* The next time you meet, ask the client if they used the information to any extent; if not, why not; and, if so, what happened. Some clients benefit more than others from psychoeducation, and you will find that they often use it far differently than you anticipated.

Try It Yourself

Find a partner and provide some psychoeducation using the steps above with a concept from this chapter.

Psychoeducation Example: Wellness Shandra was working with a 43-year-old business executive who complained of "losing his zest for life." He states that he "loves" his wife and two kids but works long hours during the week and constantly checks his email and phone on the weekend. During the lifestyle assessment, you learn that one of his basic mistake assumptions is that he believes his value as a person is tied to his work performance, resulting in a nagging sense that he always needs to be working to ensure his worth. He readily agrees to this interpretation in the insight stage and is ready to make changes in the reorientation phase. That's when Shandra believes that he is ready to learn more about *wellness*:

Shandra: "Last week, we began talking about creating greater balance between your work and home life. So, I thought it might be useful to share some information about *wellness*." "Would you be interested in hearing what I have to say?" [Ask permission]

Ricardo: "Sure. That sounds like something I need to be thinking about."

Shandra: "When counselors and psychologists think of wellness, they put it on a continuum with illness/unhappiness and health."

She draws this on the whiteboard:

Wellness ——————— Health ——————— Illness/Unhappiness

"We all know what illness and unhappiness is: something is 'wrong': we feel sad, angry, unhappy; this is where you were at when you first came to see me. Then there is health; it's the absence of illness or problems. That's closer to where you are right now: you are starting to feel less sad about things in your life. But then there's wellness. Wellness refers to an overall sense of *well-being*—mind, body, spirit—and not just the absence of problems or illness. One of the major differences between wellness and health is that a person actually needs to take proactive steps [Ricardo is

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a professional and understands words like this, so it's okay to use; otherwise, say 'make a choice to do things'] to achieve wellness, usually by adopting habits that lead to a sense of well-being. I want to pause here and see if you are following me or have any questions." [She kept it brief; one major term defined; illustrated it on a board; and checked in to see if the client understood.]

Ricardo: "Yes, yes. It kind of puts words to what I think I need to do. I can see that I am going to have to do some things differently—and I don't like that—but I think I know what you are saying is true."

During the rest of the session—*for the next 48 minutes*—Shandra will help Ricardo identify one—and only one—way to implement this idea (task setting), such as how he is going to get through the weekend without checking email so that he can focus his energy on his family. Shandra will refrain from providing more psychoeducation (it's so easy to turn a session into a classroom) and will instead focus on applying the information. If Ricardo is able to apply this information, next week she can share another bit of research from positive psychology that he may benefit from.

Homework

Often as a follow-up to psychoeducation and task setting, Adlerian counselors assign "homework," tasks to be completed between sessions (Manaster & Corsini, 1982). Homework assignments can vary widely, depending on the phase of counseling and the particular issues a client is working on. Examples of homework include the following:

- Call an estranged relative.
- Go on a date with your wife (this week or once a week).
- Develop a detailed list of things you are afraid of that hold you back at work. The next time you begin to feel inferior, write a list of the evidence "for" and "against" this perception.
- Identify friends who you could reconnect with to extend your social circle.
- When you come home at night, begin the evening by thanking or appreciating your spouse for something that she did rather than complaining about something that didn't get done.

Interpretation of Symptoms

During the third phase of Adlerian counseling, counselors "interpret" the purpose of symptoms to provide client's insight into their situation. Distinct from psychoanalytic forms of interpretation, Adlerian interpretation attempts to identify *the purpose of the symptom* and its role in the client's style of life (Ansbacher & Ansbacher, 1956; Sweeney, 2009). For example, based on the lifestyle assessment, a counselor may interpret a person's procrastination as a way of avoiding taking a risk and possibly failing. General guidelines for offering Adlerian interpretations include the following:

- *Purpose focused:* The interpretation should focus on the *goal* or *purpose* of a *behavior* (e.g., procrastination) and avoid globally labeling the person (e.g., lazy, fearful, lacking drive).
- *Tentatively offered:* Interpretations should be offered *tentatively* rather than as an unquestionable truth (e.g., "Could it be that you procrastinate to avoid taking the risk of failing?").
- *Open to revision:* Counselors should encourage and allow the client to rephrase or even correct the counselor (e.g., "It's not so much that I am avoiding risk as much as I am simply afraid to fail." *or* "No, I don't think that is my issue. I think I am saying yes to things I don't want to do.").
- *Strengths emphasis:* The overall tone of the interpretation process should be encouraging, highlighting potential strengths, hope, and resilience (e.g., "So in some ways the procrastination has served to create a sense of safety, but it seems that you may not need that as much as you did in the past.").

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Self-Concept Statements

Adlerians listen for *self-concept statements*; these are statements that clients make that reveal how they see themselves. Carlson et al. (2006) identify three types of self statements that counselors target for intervention:

1. *Inferiority-based self statements:* The client's self-concept falls short of his or her *personal* self-ideal (e.g., "I am stupid, worthless").
2. *Inadequacy-based self statements:* The client's self-concept falls short of what the client believes is the "worldview" or cultural values (e.g., "I am incompetent, a fool, a loser").
3. *Guilt-based self statements:* The client's self-concept falls short of ethical or moral beliefs (e.g., I'm bad, evil, unforgivable).

When counselors hear these types of statements, they help the client explore the comparison process and how to develop more useful, fair, and accurate comparisons. In some cases, clients are making poor decisions of which they feel guilty; the counselor then helps them identify how this happened and how to remedy it. In other cases, clients rigidly try to apply unrealistic standards of superiority; counselors can help these clients explore how they developed these and replace them with more realistic and fair evaluations of themselves. In the case study at the end of this chapter, the counselor uses self statements to help Budi develop a sense of self that is not based on his ability to take care of others and instead learn to engage in more egalitarian relationships in which his needs are also considered.

Challenging and Reframing Basic Mistakes and Private Logic

Once clients have achieved sufficient insight, counselors may directly *challenge* the logic or realism of a person's private logic or more gently *reframe* belief so that it is more useful. An example of challenging basic mistakes, counselors may ask clients who believe they must be superior to others "what would happen if everyone had that belief?" (Carlson et al., 2006, p. 140). Counselors can then follow up with questions that highlight the impossibility of a world in which all people are better than everyone else and the ugliness of a world in which everyone lived by this belief. Similarly, in many cases, negative situations can be *reframed* in more positive ways. For example, "The upside of worrying is that you tend to be good with details." Counselors can use positive reframing to simultaneously encourage clients and undo basic mistakes.

Natural and Logical Consequences

Introduced by Dreikurs, consequences take two forms in Adlerian counseling—natural and logical—and are used primarily with children (Mosak & Maniacci, 1999; Sweeney, 2009). *Natural consequences* require no conscious human intervention; they occur as part of the physical or social environment. If a child does not do his homework, he loses points, he does not learn, and his grades suffer. If you say harsh words to your friend, you weaken or lose the friendship. Whenever possible, Adlerian counselors encourage parents to use natural consequences to help children and others learn from experience. However, if natural consequences are not readily apparent or sufficient, then logical consequences are used instead to *encourage* children to make better decisions (e.g., if you are unable to keep your toys neat and tidy, then you have more toys than you can manage, and some will be taken away until you can manage what you have effectively). Such consequences and encouragement are preferred to behavioral systems of punishment and reward.

Antisuggestion

A classic Adlerian technique, the *antisuggestion* is a type of *paradoxical technique*. The antisuggestion involves the counselor taking the paradoxical position of discouraging change and/or encouraging the symptom, particularly when the client claims that a symptom is "uncontrollable" (e.g., worrying or getting nervous; Ansbacher & Ansbacher, 1956;

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Carlson et al., 2006; Sweeney, 2009). Antisuggestions can be used in session or out of session. For example, in situations where this is appropriate and safe, the counselor can suggest that the client practice exaggerating a symptom, such as spending extra time worrying every morning:

> "For the next week, I want you to set a timer and worry for 10 minutes before you leave the house. If you find you run out of things to worry about after a few minutes, I want you to really try to find more things to worry about. I want you to worry later in the day, that is fine, too. But I want you to schedule ten minutes each morning and do it whether you feel like it or not."

Clients who follow through on this task will quickly gain insight into how they generate worry and anxiety. When asked to worry on cue, it is difficult, even for those with an anxiety disorder. In the process of "forcing" the symptom, the client gains more and more control over it; thus, when it spontaneously occurs clients are better able to consciously stop worrying.

Spitting in the Soup

An attention-grabbing name for a counseling technique and more hygienic than it sounds, *spitting in the soup* refers to making overt the covert benefits and hidden power of having a symptom. Once the ulterior benefits of the symptoms are revealed, the symptom leaves a "bad taste." Here are some examples:

- The one benefit of depression is that you have gotten everyone in your family to pay more attention to you.
- You must have reached near rock-star status to have everyone in the subway looking at you.
- The nice part about panic is that you get your wife to end the shopping trip early—it even saves you money.
- It must be very rewarding to know that no other mother at the school worries this much about her children.
- The great part about temper tantrums is that it fills up your toy chest fast.

Interventions for Special Populations

Couples and Families

Numerous counselors and therapists have developed the Adlerian approach for working with couples and families. Adler and Dreikurs developed the world's first child guidance clinics in Vienna before World War II, making the Adlerian approach perhaps the first family counseling approach. Dreikurs spent most of his career developing approaches for working with children. More recently, Dinkmeyer and McKay (2007) have developed an evidence-based parent education program using Adlerian principles (see "Snapshot: Research and the Evidence Base").

Carlson et al. (2006) describe a brief Adlerian approach to couples counseling that involves four steps:

> *Step 1: Relationship:* The counselor begins by developing a relationship in which both members of the couple feel heard and understood and encourages each partner to access his or her resources and best parts of themselves.
>
> *Step 2: Assessment:* Next, the counselor helps the couple to better understand their styles of lives, including the beliefs, feelings, motivations, and goals that underlie problem behaviors in the relationship. For example, a partner's apparent "lack of interest" or "distance" may be an expression of one partner's sense of inferiority; similarly, the other partner's "demands for attention and connection" may be an expression of the other partner's inferiority and/or need for belonging. The counselor would help both partners to better understand the dynamics that motivate the behavior of each and how these individual dynamics inform their couple interactions.

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Step 3: Insight: Using information gathered from the assessment, counselors help couples gain insight into each person's personal beliefs, feelings, and goals and how these translate to problematic couple dynamics. The counselor may use psychoeducation to facilitate this process.

Step 4: Reorientation: Once couples gain insight, they are ready to take action and find alternatives to the problem behavior. The counselor works with the couple to find strategies that help them change their behaviors and sustain these new relational skills.

Putting It All Together: Adlerian Case Conceptualization and Treatment Plan Templates

Theory-Specific Case Conceptualization: Adlerian

Use the prompts below to develop a theory-specific case conceptualization; the case study at the end of the chapter provides an example.

Lifestyle assessment to include the following:

- *Social interest and inferiority*
  - *High social interest*: generally has few symptoms or mild presenting issues
  - *Low social interest, successful person*: power, position, possessions
  - *Low social interest, failure*: complaining, blaming, fears, excuses
- *Parenting style:* Describe:
  - General character of each parent (primary caregivers), including personalities, trauma histories, values, ethnic/religious background, etc.
  - Quality of client's relationship with parents (primary caregivers) and their parenting styles.
  - Whether physical, psychological, and emotional needs were taken care of.
  - How client got what he/she wanted from parents.
- *Family constellation and birth order:* Describe family organization including:
  - Client's birth order: oldest, second, middle, youngest or only child.
  - Role of siblings in client's and family's life.
- *Earliest recollections:* Describe two to five of the client's earliest recollections, including:
  - Memory narrative
  - Most vivid moment of the memory
  - Predominant feeling associated with the memory
- *Organ inferiority or physical weak points:* Describe any physical weaknesses or limitations.
- *Role of symptom:* Describe the client's answer to the question: what would be different in your life if you didn't have the problem?
- *Basic mistakes:* Describe the client's basic mistake beliefs, including those related to:
  - Overgeneralization
  - False or impossible goals of security
  - Misperceptions of life and life's demands
  - Minimization or denial of one's basic worth
  - Faulty values
- *Style of Life Theme:* Describe basic theme of client's style of life:
  - Control
  - Superiority
  - Pleasing
  - Comfort
- *Life tasks:* Describe level of social interest and general functioning in each of the life task areas:
  - Work
  - Communal life and friendship

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- Love relationships
- Self-acceptance
- Spirituality
- Parenting

Treatment Plan Template: Adlerian

Use this treatment plan template for developing a plan for clients with depressive, anxious, or compulsive types of presenting problems. Depending on the specific client, presenting problem, and clinical context, the goals and interventions in this template may need to be modified only slightly or significantly; you are encouraged to significantly revise the plan as needed. For the plan to be useful, goals and techniques should be written to target specific beliefs, behaviors, and emotions that the client is experiencing. The more specific, the more useful it will be to you.

Treatment Plan

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration*: [Describe how you will specifically adapt your approach to be sensitive to client diversity when developing the counseling relationship; this may include respecting cultured and gendered norms for emotional expression.]
   Relationship building approach:
   a. Use **encouragement**, **empathy**, and **education** to create an **egalitarian relationship** in which the client has a sense of **free will**.
2. Assess *individual, systemic, and broader cultural dynamics. Diversity consideration:* [Describe how you will specifically adjust assessment based on cultural, socioeconomic, sexual orientation, gender, and other relevant norms.]
   Assessment strategies:
   a. Assess **lifestyle**, **basic mistake**, **parenting style**, **family constellation, early recollections**, **organ inferiority**, and **dreams**.
   b. Use "**the question**" to help determine purpose of symptom and goals for treatment.

Initial Phase Client Goals

1. *Decrease* insecurities and **basic mistake assumptions** that fuel crisis thinking and behaviors to reduce [specific crisis symptoms].
   a. **Psychoeducation** on how to manage [crisis behavior]; **encouragement** to follow through with new response to feelings that signal crisis.
   b. Challenge **basic mistake** and assumptions related to crisis thoughts and behaviors.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* [Describe how you monitor the client's ongoing sense of connection with counselor and how you will specifically adapt monitoring and/or relationship based on client age, gender, cultural, sexual orientation, socioeconomic, etc.].
   Assessment Interventions:
   a. Monitor for signs that client has a sense of equality and ownership in relationship.

(*continued*)

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Working Phase Client Goals

1. *Decrease* **insecurities** that lead to [specific dynamic or problem] to reduce [specific symptoms: depression, anxiety, etc.]
   Interventions:
   a. **Psychoeducation** to correct basic mistake belief: [specify].
   b. Challenge unrealistic **self-concept statements** and **basic mistake beliefs:** [specify].

2. *Decrease* avoidance of **life tasks** and/or **social connections** in [specify: work, relationship, communal, etc.] contexts to reduce [specific symptoms: depression, anxiety, etc.].
   Interventions:
   a. **Interpretation** of avoidance behaviors in terms of how they enable client to avoid misguided childhood fears, social contact, key life tasks, and so on.
   b. **Spitting in soup and antisuggestion** techniques to unmask how symptoms allow client to avoid feared life tasks.

3. *Decrease* tendency to **value self** based on external achievements and approval from others to reduce [specific symptoms: depression, anxiety, etc.].
   Interventions:
   a. Challenging **basic mistake belief** that self-worth is based on performance and approval from others.
   b. Alter **self-concept statements** to reflect a more realistic valuing of self that focuses on "what am I doing?" rather that "how am I doing?"

Closing Phase of Treatment

Closing Phase Counseling Tasks

1. *Develop aftercare plan and maintain gains. Diversity consideration: [Describe how you will access resources in the communities of which they are a part to support them after treatment ends.].*
   Intervention:
   a. **Psychoeducation** on **wellness and positive psychology** to identify key components to maintaining happiness and well-being.

Closing Client Goals

1. *Increase* **self-acceptance** and overall sense of wellness to reduce potential for relapse of symptoms.
   Interventions:
   a. **Psychoeducation** on **social interest** and **positive psychology** to develop habits of wellness, such as a strong social network, gratifying activities, and optimistic basic assumptions.
   b. Examine **natural consequences** of acting from **social interest versus basic mistake** assumptions.

2. *Increase* **social connections** in intimate relationships and work contexts [and/or parenting, spiritual contexts] to reduce potential for relapse of symptoms.
   Interventions:
   a. **Psychoeducation** on importance of functioning in all **life tasks** to achieve balance.
   b. Develop homework and life habits that support **social interest** in all areas of living.

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Tapestry Weaving: Working with Diverse Populations

Ethnic and Racial Diversity

Although one of the oldest approaches, Adlerian theory has had, from its inception, surprisingly modern feminist and multicultural values (Mansager, 2008; Newlon & Arciniega, 1983). Alfred Adler defined mental health as having high levels of social interest, community feeling, and empathy for others, even those others who are quite unlike oneself (Ansbacher & Ansbacher, 1956). He clearly and frequently referred to the subjugation of women and their unfair treatment and considered this in his assessment and diagnosis; although such practices seem commonplace today, it was a radical stand for social justice in the 1910s. More recently, Adlerians have also been advocates for gay, lesbian, bisexual, and transgendered individuals (Mansager, 2008; see Sexual Identity Diversity section below).

Several of the theory's central concepts make Adlerian Individual Psychology particularly well suited for working with diverse clients:

- *Social Interest:* The emphasis on social interest is particularly appropriate for traditional and collectivist cultures that value family and community over individuality and independence. Furthermore, the primary goal of the approach is to help people develop a greater sense of "community feeling" and connection with one's broader community; this is exceptionally important for marginalized populations, whether ostracized due to their sexual orientation, language abilities, physical abilities, or ethnic origin. By definition, the primary means of reducing a sense of marginalization is to create a feeling of belonging. As the default goal of this approach, it is a natural fit for persons who feel marginalized from specific communities or dominant society.
- *Superiority, Racism, and Other -isms:* Adler viewed any attempts to see oneself as superior to another human being as a sign of maladjustment, thus providing a strong antiracist, antisexist, and antiheterosexist foundation to his theory (Mosak & Maniacci, 1999).
- *Spirituality:* Whereas many theories either ignore or are suspicious of religion and spirituality, the Adlerian theory views a persons' relationship to something greater as an important relationship to cultivate (Carlson et al., 2006; Sweeney, 2009). This emphasis on spirituality is consistent with values in many traditional cultures and ethnic groups.
- *Social Factors Impacting Mental Health:* Adler carefully assessed and considered the impact of broader social and family factors in the development of problems. Individuals and their symptoms were considered in the context of the *environment*, an important practice when working with persons from minority and marginalized groups.

When working with diverse clients, Adlerian counselors consider some of the following when establishing a counseling relationship, assessing, designing treatment, and intervening; these points can be identified when appropriate in the "Diversity consideration" section of the treatment plan.

Developing and Monitoring the Counseling Relationship with Diverse Clients

Expression of Encouragement How a client receives a counselor's expression of "encouragement" very much depends on multiple dynamics in the relationship: the age and gender of each; the ethnicity and social class of each; and the perceived disparity in general functioning. For example, men with a more traditionally defined sense of masculinity, those with cultural norms that value saving face, or clients whose counselor is significantly younger may find certain expressions of encouragement (e.g., "I know you can do it") as off-putting or even offensive, whereas the same words between a different configuration of client-counselor may be very effective. Thus, Adlerian counselors carefully

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attend to variables such as age difference, cultural norms, and gender dynamics when they express encouragement with their clients, to ensure that their expression of encouragement strengthens rather than jeopardizes the counseling relationship.

Examples of Noting This Diversity Dynamic in Treatment Planning

- Offer expressions of encouragement that allow client to still feel sense of competence/save face.
- Avoid expressions of encouragement that may be experienced as emasculating.
- Ensure that expressions of encouragement show respect for client's achievements and maturity.

"Egalitarian" Relationships with Diverse Clients The Adlerian value of creating an egalitarian relationship with clients quickly becomes complicated when working with diverse clients. For counselors with liberal or modern sensibilities, it may be surprising to learn that not all clients appreciate an egalitarian relationship with their counselor or therapist. Many traditional cultures see "healers" such as doctors and counselors as having a special and higher position in the community and therefore may be more comfortable with the counselor taking an expert position (Qureshi & Collazos, 2011). Furthermore, even when striving toward equality, it is arguably difficult to declare any relationship as truly "egalitarian" because of the many forms of social power at play; this dynamic is even more pronounced between counselors and clients with diverse backgrounds (Monk, Winslade, & Sinclair, 2008).

Thus, when developing relationships with clients using the Adlerian concept of egalitarianism, counselors consider an appropriate form and expression of this theoretically grounded value. Most critically, when a counselor from a more privileged social position (such as a particular ethnic/racial background, gender, sexual orientation, or social class) works with clients from more marginalized social positions, the counselor must consider the unique client needs and how to best promote the client's sense of agency, which is the underlying purpose of the egalitarian position (Sweeney, 2009). In some cases, promoting agency may involve emphasizing the egalitarian nature of the relationship by frequently inviting client expertise into the conversation, to actively undo a perceived status difference such as social class or age. With other clients, the counselor may best achieve a sense of egalitarianism by honoring a cultural preference for a more formal counselor–client relationship with some elements of hierarchy, while still promoting a sense of client agency through more subtle expressions of encouragement. In sum, the best measure of whether the relationship is appropriately egalitarian is whether the client feels a sense of agency in session and is able to transfer this to their everyday life.

Examples of Noting This Diversity Dynamic in Treatment Planning

- Build sense of egalitarianism due to age/gender differences [or list other differences] by frequently asking for client perspectives rather than providing expert answer.
- Use self-deprecating humor to increase sense of egalitarianism in relationship.
- Balance client's desire for "expert" help with reflections that build client sense of agency by asking for input and preference.

Assessing Individual, Systemic, and Broader Cultural Dynamics with Diverse Clients

Superiority, Racism, and Other -isms Adler viewed any attempts to see oneself as superior to another human being as a sign of maladjustment, thus providing a strong antiracist, antisexist, and antiheterosexist foundation to his theory (Mosak & Maniacci, 1999). These forms of attempted superiority stem from an underlying sense of inferiority, basic mistakes, and low social interest. Thus, when assessing clients, counselors attend to where and how clients may be marginalized in one way or another by such views.

Examples of Noting This Diversity Dynamic in Treatment Planning

- Assess for how the client may be experiencing racism, sexism, heterosexism, ageism, etc. in their personal, professional, and/or community contexts.

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- Assess for contexts in which client may be experiencing harassment and marginalization due to sexual orientation, race, immigration status, social class, etc.

Lifestyle Assessment with Diverse Clients The assessment of lifestyle, with its emphasis on childhood experiences and early recollections, may not seem relevant to people who prefer a more pragmatic approach or who do not share the dominant Western assumption that these events shape a person's personality. Therefore, counselors may want to take time to explain the rationale for such assessment and/or limit it when working with clients who may not see its value.

Furthermore, to properly assess a diverse client's style of life, counselors should take time to educate themselves about the culture, including cultural values, immigration patterns, class differences, and acculturation patterns. For example, Reddy and Hanna (1998) describe how Hindu women are shifting from a more traditional pleasing and dependent lifestyle to a more contemporary style of interdependence and assertiveness, especially in upper classes more likely to immigrate. Similarly, Duffey, Carns, Carns, and Garcia (1998) describe how middle-class Mexican American women are combining traditional Mexican cultural values with contemporary values, becoming both collaborative and self-promoting. Finally, Chung and Bemak (1998) provide insight into the lifestyles of immigrant Vietnamese women, who must try to bridge two vastly different cultures often in the context of significant preemigration trauma.

Examples of Noting This Diversity Dynamic in Treatment Planning

- Focus lifestyle assessment on better understanding client's cultural/ethnic background [and/or immigration or marginalization experience].
- Ensure client is comfortable with and values exploring past as part of lifestyle assessment.
- Provide explanations for purpose of discussing childhood experiences if client uninterested or resistant.

Spirituality Whereas many theories either ignore or are suspicious of religion and spirituality, the Adlerian theory views a person's relationship to "something greater than the self" as an important relationship to cultivate (Carlson et al., 2006; Sweeney, 2009). This emphasis on spirituality is consistent with values in many traditional cultures and ethnic groups, and thus can be an area of particular focus when working with clients from diverse populations.

Examples of Noting This Diversity Dynamic in Treatment Planning

- Include detailed assessment of potential religious/spiritual resources, including community support and spiritual practices that promote well-being and help cope with stress.
- Include assessment of client's religious community and its role in personal and family life.

Setting Goals and Monitoring Progress with Diverse Clients

Social Interest as a Value The Adlerian goal of developing social interest is particularly salient for cultures and subcultures that value family and community over individuality. In such cases, social interest coincides with many traditional cultural values and thus may be a welcomed and particularly salient long-term goal. Furthermore, the goal of developing a greater sense of "community feeling" and connection with one's broader community is often important for long-term well-being of marginalized populations, whether due to their sexual orientation, language abilities, physical abilities, or ethnic origin.

Nonetheless, it is important to remember that the particular form of expression of social interest may vary dramatically across cultures, social classes, age groups, genders, religious groups, and even personalities. All clients may not agree to goals that relate to increasing social interest across all areas identified as salient to Adlerians: communal life, work, love relationships, self-acceptance, spirituality and parenting (Carlson et al., 2006;

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Sweeney, 2009). Therefore, when setting goals and monitoring progress, counselors may need to adjust these to meet specific client values and beliefs.

Examples of Noting This Diversity Dynamic in Treatment Planning

- Inquire about client views and values related to life tasks and social interest.
- Identify forms of social interest appropriate to cultural/religious background.
- Adjust goals to coincide with cultural/religious values.
- Check to ensure that client progress coincides with client views/goals.

Developing Plans for Aftercare and Maintaining Gains

Building Community and Social Interest The emphasis on social interest in Adlerian counseling provides an excellent foundation for helping clients maintain gains after counseling services end. As repeatedly noted by positive psychologists, people with strong social networks are more likely to report being happy and fulfilled (Leak & Leak, 2006). Thus, by helping clients develop stronger social interest in multiple areas of life, they are more likely to have sufficient social networks to support them going forward without treatment. Of particular importance, many clients who are part of marginalized communities often have access to particularly supportive and readily identifiable support networks, such as support groups, social networks, and formal organizations. Counselors should familiarize themselves with local resources as well as work with clients to identify suitable connections to ensure clients are well connected before ending counseling services.

Examples of Noting This Diversity Dynamic in Treatment Planning

- Help client connect with support network through religious organization.
- Help client connect with support in gay/lesbian community.
- Help client connect with support offered by extended family.

Sexual Identity Diversity

Although ahead of his time in terms of gender and socioeconomic injustices, Adler was not as forward-thinking on the issue of sexual orientation. Similar to psychodynamic theory, Adlerian theory historically conceptualized same-sex attraction as a form of neurosis (Chernin & Holden, 1995; Mansager, 2008). However, contemporary Individual Psychology practitioners have gone to significant lengths to correct this history. Most notably, contemporary Adlerians have formally a) admitted that historically this approach has unfairly and inaccurately pathologized same-sex attraction, b) publically apologized to any LGBT individuals who have been hurt by these erroneous theoretical conceptualizations, c) amended the work of Individual Psychology to correct and improve the theory, and d) assured professionals and the public that Individual Psychology affirms and promotes the well-being of LGBT individuals (Mansager, 2008).

As part of the theory's reconceptualization of same-sex attraction, Fisher (1993) identifies three issues that are unique to working with gay and lesbian couples using Alderian theory:

- *Feelings of Inferiority Projected on to Self and Relationship:* Because gay and lesbian individuals experience profound and multiple forms of societal rejection, their style of life is typically dominated by feelings of inferiority both personally and about their relationships; this self-hatred is often referred to as homophobia. These feelings of inferiority are extremely detrimental to relationships, often the source of conflict for the couple.
- *Lack of Positive Role Models:* Gay and lesbian couples often lack positive role models to guide them in forming mutually satisfying relationships. Often they resort to modeling their relationship on their parents' heterosexual relationship, which typically is ineffective and problematic.
- *Lack of Social Interest if "Closeted":* If one or both partners are "closeted," cultivating social interest—which is correlated to well-being—is extremely difficult

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to cultivate. Because their focus is on protecting the self from society, closeted individuals have greater difficulty attending to the needs of their partner or the community more broadly. Couples who are out of the closet to different degrees are also likely to experience tension and conflict over these differences, too.

When conducting a lifestyle assessment with gay and lesbian clients, Fisher (1993) recommends adding the following questions:

- When did you first remember having same-sex attractions? Can you describe the experience and how you felt about it?
- What were your mother's views about same-sex attraction? Your father's? Siblings?
- How did you first know you were gay/lesbian/bisexual? Did you tell anyone, and, if so, how did they respond? How did you feel about yourself initially?
- How did you feel about gay/lesbian/bisexuals in general at that time? How do you feel now?
- Have you ever known anyone who is LGB that you loved and respected?
- To whom have you "come out" and why? Who have you chosen to not come out to and why?
- What qualities do you seek in a partner? Who do you use as a model for healthy relationships?

Research and the Evidence Base

Adlerian counseling has not been carefully examined in clinical trials due to difficulties in operationalizing terms, such as social interest, as well as a general sense on the part of practitioners that their theory works (Sweeney, 2009). However, *Systematic Training for Effective Parenting (STEP)* is a notable exception; this Adlerian-based parenting program is listed as "promising" evidence-based treatment for parent training.

Research studies on Adlerian theory have focused on parent–child and teacher–child relations. For example, McVittie and Best (2009) conducted a study on the effectiveness of an Adlerian-based parenting program; their large-scale, self-report study indicated that parents reported setting clearer limits, increasing their sense of positive connection, and decreasing harshness. Similarly, Kelly and Daniels (1997) studied the effect of teachers using praise versus encouragement on children in fourth through tenth grade; they found that teachers who used encouragement were viewed as more potent than those using praise. Pilkington, White, and Matheny (1997) studied the correlation of birth order on coping resources in school-aged children and found some support for differences between the oldest and middle children, with the former having the highest level of coping and the latter the lowest. Despite these initial studies, Adlerian theory and practice would benefit from more detailed research studies on the methods and effectiveness of this approach.

Evidence-Based Treatment: Systematic Training for Effective Parenting (STEP)

Systematic Training for Effective Parenting (STEP) is a promising evidence-based parenting program based on Adlerian principles (Dinkmeyer & McKay, 2007). The STEP program has been researched for almost four decades (Gibson, 1999) and is currently listed as a "promising practice" by state and federal agencies. Using Adlerian principles, the STEP program is an extremely positive parenting approach that uses encouragement, appreciation, and motivation to improve child behaviors and parent–child relations. At its heart, it helps parents develop social interest and cooperative behaviors and directly addresses the classic Adlerian concept of developing "courage to be imperfect." The programs include a specific program for children under six (Dinkmeyer & McKay, 2008) and one for teens (Dinkmeyer, McKay, & McKay, 2007).

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The program includes lessons on:

- Understanding yourself and your child
- Understanding beliefs and feelings
- Encouraging your child and yourself
- Listening and talking to your child
- Helping children learn to cooperate
- Discipline that makes sense
- Choosing your approach

Adlerian Case Study

Budi, a 44-year-old Indonesian immigrant, reports that, although he has often been down before, the past two years have been very bad. The depression began (or got much worse) after his diagnosis with a debilitating nerve condition that has required him to be wheelchair-bound; there is little hope of return to normal functioning. He still works and enjoys working. He is generally a quiet man who reads and is a serious chess player who enters amateur contests. He is married and has a 3-year-old daughter. He immigrated to the United States to pursue education as an engineer. The eldest of four children, he planned to return home after college but remained in the United States to help support his family back home. He grew up in a traditional Indonesian Muslim family; the family was close-knit, a clear family hierarchy was observed, sensitive issues were not directly discussed, and shame was avoided at all costs. Children were expected to be obedient.

Case Conceptualization: Adlerian

This case conceptualization was developed by selecting key concepts from "The Viewing: Case Conceptualization" section of the chapter. You can use any of the concepts in that section to develop a case conceptualization for this or other cases. Lifestyle assessment to include the following:

- Social interest and inferiority
- Parenting style
- Family constellation and birth order
- Earliest recollections
- Organ inferiority or physical weak points
- Role of symptom
- Basic mistakes
- Style of life theme
- Life tasks

Social Interest and Inferiority

Overall, AM (adult male; confidential notation for client in case) is a "low social interest, successful person" who focuses more on *how* he is doing in life than what he is doing. His focus is on whether he is able to support and provide for others, and at this level he is socially engaged and demonstrates many positive elements of social interest. However, rather than building social connections that are personally rewarding and fulfilling, his social interactions are focused on gaining social approval; this lack of focus on himself has led to his periods of feeling down and depressed.

Parenting Style

AM's parents raised him in traditional Indonesian family structure in which there were clear hierarchical lines, with father in charge, then mother, then AM (as the eldest), with grandparents having considerable influence over the family. His parents were relatively strict and made clear their expectations for him to be a role model and caretaker

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for the younger children. His place in the family earned him privileges that the other children did not receive, but often left him feeling separate or alone in the family since he was not an adult but was seen as separate from the other children in many ways. He was closest to his maternal grandmother, who often relaxed the rules for him. AM has tried to bring more warmth to his relationship with his young daughter, but by American standards, he maintains a cool, somewhat removed role in her life.

Family Constellation and Birth Order

AM aptly characterizes the typical eldest child in Indonesian culture. He has taken seriously his responsibility to his family, sending money home each month to support them. His childhood involved significant responsibility in caring for his siblings and pressure to serve as a good role model. He has continued to strive for superiority as an adult.

Siblings

- Sister: AF 42 (2 years younger): Gregarious and friendly, she was the opposite of AM 44 in many ways. They have a cordial relationship, and AM knows he can rely on her to help take care of the parents and family. She is a stay-at-home mother.
- Brother: AM 40 (4 years younger): An energetic risk-taker, AM 44 has always felt a need to keep an eye on his younger brother, who went through a rebellious period in his teens. They had a period of feeling close when they were both young, but they now maintain a more formal relationship. AM 40 now works as a mechanic and has recently started a family; AM 44 hopes that they may now have more in common with the start of his family.
- Sister: AF 36 (8 years younger): The youngest of the family, AF 38 always enjoyed being the center of attention and protected by her older brother and father. She married young, has three children, and works in retail.

Organ Inferiority or Physical Weak Points

AM's recent nerve degeneration that has resulted in his being wheelchair-bound has created numerous and multilayered forms of stress. First, since his identity has been built around his ability to care for others, this new role is scary because it is unfamiliar and because it threatens his ability to do the very things from which he derives his fragile sense of connection and worth. In addition, it greatly limits his ability to live life as he is accustomed. Although he has continued to work and engage in most family activities, he is no longer able to engage in sports and avoids most social activities because of the hassle. Finally, because his diagnosis is not final, he still holds out hope that things may improve and he cannot accept current circumstances.

Earliest Recollections

- When he was about 4, his family was visiting a family with whom they were friends. While visiting, he broke a special vase. Without saying anything, his father smacked him hard across the face (most vivid part); he became so scared he wet his pants. He reports feeling humiliation; as well as feeling worthless in his father's eyes.
- When he was 6 and taking caring of his 4-year-old sister, she got her fingers badly smashed in a door; her fingers were bleeding and left blood in the door jam (most vivid part). His mother became very angry and beat him, which she rarely did. He remembers feeling shame and a sense of failure.
- When he was age 7, he remembers playing with his brother and sister at the beach, digging in the sand (most vivid part) and playing in the water. This is one of his best childhood memories; he felt close to them. He associates feelings of fun and freedom with this memory.

Role of Symptom

If his depressive symptoms were not a problem, AM states that he would enjoy playing with his children, return to competitive chess competitions/conferences, and travel again—with or without improvement in his nerve condition.

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Basic Mistakes

AM's basic mistake assumptions are rooted in his early role in the family as a caretaker for his siblings, namely, the following:

- I must put my selfish desires second in order to care for others and to ensure that the family's basic needs are met.

Style of Life Theme

AM style of life is characterized by seeking superiority, which includes immigrating to the United States to pursue a professional career and choosing to support his family back home. He strives to be an upstanding member of his family and larger community, avoiding shame at all costs. His current physical condition significantly challenges his ability to maintain his sense of self, which up to this point has always been defined by seeking to be ever-better in all facets of his life. For the first time, he is confronting what seems like an insurmountable challenge.

Life Tasks

In many ways, AM has done well to address many key life tasks. He has a profession that he enjoys and a family he is connected to. However, he does not have an extensive friendship or community life in the United States, although he does have friends with whom he plays chess. Although raised a Muslim in Indonesia, he has not practiced much in the United States but still maintains a belief in God.

Treatment Plan: Adlerian

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration:* Carefully approach issues that might cause shame or be too direct; maintain a more formal, respectful tone and approach.
   Relationship building approach:
   a. Use **encouragement**, **empathy**, and **education** to create an **egalitarian relationship** in which AM has a sense of **free will** and choice.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Adapt for cultural norms and family roles.
   Assessment strategies:
   a. Assess **lifestyle**, **basic mistake**, **parenting style**, **family constellation, early recollections**, **organ inferiority**, and **dreams**.
   b. Use "**the question**" to help determine purpose of symptom and goals for treatment: If you were not depressed, what would be different? If you were not in a wheelchair, what would be different?

Initial Phase Client Goal

1. *Decrease* **insecurities** and **basic mistake assumptions** to reduce sense of hopelessness.
   Interventions:
   a. **Psychoeducation** on how to manage depressed mood related to disability; encouragement to follow through with new response to feelings that signal crisis.
   b. Challenge **basic mistake assumptions** related to depression and need to care for others.

(*continued*)

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Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* Maintain engaged, respectful tone.
   Assessment Intervention:
   a. Monitor for signs that client has a sense of **equality** and **ownership** relationship.

Working Phase Client Goals

1. *Decrease* **insecurities** that lead to need to support others to the point that his own dreams are not addressed to reduce depressed mood.
   Interventions:
   a. Psychoeducation to **correct basic mistake** belief that his value comes strictly from taking care of others at his own expense.
   b. Challenge unrealistic **self-concept statements** and **basic mistake beliefs**: If he can't care for others (because of his disability), others will abandon him.
2. *Decrease* avoidance of pursuing **personally fulfilling activities** and goals to reduce depression and increase **social network**.
   Interventions:
   a. **Interpretation** of **avoidance behaviors** in terms of how they enable client to avoid making decisions about his personal life and being responsible for his own happiness.
   b. Examine **birth order** and its effect on his life decisions and current life situation.
3. *Decrease* tendency to **value self** on the basis of external achievements and approval from others to reduce depression.
   Interventions:
   a. Challenging **basic mistake belief** that self-worth is based on approval from others.
   b. Alter **self-concept statements** to reflect a more realistic valuing of self that focuses on "what am I doing?" rather that "how am I doing?"

Closing Phase of Treatment

Closing Phase Counseling Tasks

1. *Develop aftercare plan and maintain gains. Diversity consideration:* Consider Indonesian and/or Muslim resources and visions for healthy social interest.
   Intervention:
   a. **Psychoeducation** on **wellness** and positive psychology to identify key components to maintaining happiness and well-being.

Closing Phase Client Goals

1. *Increase* **self-acceptance**, acceptance of physical limitations, and overall sense of wellness to reduce potential for relapse of depression.
   Interventions:
   a. **Psychoeducation** on **social interest** and positive psychology to develop habits of wellness, such as a strong social network, gratifying activities, and optimistic basic assumptions.
   b. Examine **natural consequences** of acting from **social interest** versus basic mistake assumptions.
2. *Increase* **social connections** in local community to reduce potential for relapse of depression.
   Interventions:
   a. **Psychoeducation** on importance of functioning in all **life tasks** to achieve balance.
   b. Develop homework and life habits that support **social interest** in all areas of living.

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Questions for Personal Reflection and Class Discussion

1. Does Adler's concept of social interest resonate with your life experience? How, or why not?
2. Do you like the idea of the counselor being encouraging? What strengths do you see with this approach? Do you see any potential problems?
3. What strengths does this approach have for working with diverse clients? What limitations?
4. What challenges do you see in conducting a lifestyle assessment with a client who is significantly different than you (e.g., gender, age, ethnicity, race, etc.)? How might you overcome these differences?
5. Where are you in the birth order of your family? Do you see yourself and/or your siblings fitting into Adler's description of birth order roles in some ways? In what ways may they not be accurate for you?
6. Do you like Adler's approach to helping all clients improve functioning in multiple areas of life? In what ways might this be a strength? In what type of situations might this be a problem for clients?

Online Resources

Journal

Journal of Individual Psychology
www.utexas.edu/utpress/journals/jip.html

Associations and Societies

International Association of Individual Psychology
www.iaipwebsite.org/public/content.php?id_cont=9

North American Society of Alfred Adler
www.alfredadler.org

Select Training Institutes

Adler Graduate School (Minnesota)
www.alfredadler.edu

Adler School of Professional Psychology (Chicago)
www.adler.edu

Adlerian Training Institute
www.adleriantraining.com

Alfred Adler Institute of New York
www.alfredadler-ny.org

Alfred Adler Institute of San Francisco and Northwest Washington
www.pws.cablespeed.com/~htstein

Link to More Resources

Link to Additional Resources from the Adler Graduate School
www.alfredadler.edu/resources/adlerianlinks.htm

Videos

See the Theory in Action Videos at Cengagebrain.com

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CHAPTER

6

Person-Centered Counseling and Psychotherapy

The good life is a process, not a state of being. It is a direction not a destination.
—Carl Rogers

Lay of the Land

This is one chapter you will want to read while fully awake. Person-centered counseling is one of the most influential and widely used approaches. Regardless of which theory you intend to use when you are done with this book, the person-centered approach to build a counseling relationship with a client will be useful to you in one way or another. But before we get to your new friend Carl, it is important to understand the philosophical foundations of humanistic-existential theories, such as person centered.

Humanistic-existential counseling approaches are grounded in phenomenological philosophy, a philosophy approach that examines a person's subjective inner reality. These approaches are sometimes referred to as *experiential* approaches because of their focus on inner experience. Although contemporary practitioners typically draw from the full range of humanistic-existential approaches, these initially developed as three separate counseling approaches:

- *Person-centered counseling (Chapter 6):* Person-centered counseling—also known as client-centered or Rogerian counseling—is one of the quintessential counseling approaches. Developed by Carl Rogers (1942, 1951), this approach is based on the assertion that three core conditions—including accurate empathy, counselor genuineness, and unconditional regard—are sufficient to promote client change. The focus is on the emotional and relational processes that promote change rather than on the use of specific techniques to achieve desired outcomes. This approach assumes that people tend *naturally* toward positive growth.
- *Existential counseling (Chapter 7):* Existential counseling is grounded in existential philosophy, which has more neutral assumptions about the human conditions in comparison to the more optimistic humanistic foundations of person-centered counseling. Existential counseling posits that clients experience symptoms and distress because they are avoiding or need to more effectively deal with broader existential issues, such as each human's ultimate separation from others, death,

(*continued*)

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loss, and existential anxiety. This approach emphasizes insight and reflection on existential issues to more effectively resolve the underlying anxiety that fuels a client's presenting concern.

- *Gestalt counseling (Chapter 8):* Similar to person-centered counseling, Gestalt counseling is a humanistic approach that focuses on helping people to self-actualize or to become more fully themselves. However, the techniques are more emotionally provocative and confrontational than the person-centered approach.

Philosophical Foundations

Compared to the analytic chapters, traditional philosophy plays a much more central role in humanistic-existential therapies (similar to the postmodern therapies in Chapter 13, where you will also have to spend some clear-headed time with philosophers). So, here is a brief review of the threads of philosophical discourse that provided the foundation for person-centered as well as existential and Gestalt therapies.

Phenomenology

These three counseling approaches are grounded in the same general philosophical tradition: phenomenology. Phenomenology refers to the study of human consciousness: our *inner* lives, particularly our emotions. This is in contrast to approaches that are based on logical positivism, which focuses on external, objective reality (i.e., cognitive-behavioral approaches). In contrast, phenomenology focuses on *subjective*, inner reality that cannot be easily observed or measured. Thus, the counselor relies heavily on clients' *self-report* as to what they are experiencing, combined with a general understanding of how emotion and cognition work. Well-known philosophical phenomenologists include Edmund Husserl, Martin Heidegger, Paul Ricoeur, and Alfred Schutz.

Humanism

In broad—and therefore oversimplified terms—*humanists* tend to be the more optimistic phenomenologists. A specific expression of phenomenology, humanism is based on the premise that all people tend naturally toward positive growth, and thus humanists exude bountiful hope and enthusiasm and have faith in everyone's potential for growth. The role of the humanistic counselor is to *remove the blockages* to this natural tendency of self-actualization rather than remediate deficiencies. The counselor serves as a type of midwife who assists in fostering the natural growth and development process rather than as a technician who facilitates change. Activists in the humanistic tradition include Abraham Maslow, William James, Thomas Mann, Albert Einstein, and Kurt Vonnegut.

Existentialism

Existentialists are the realists in phenomenological circles. They view life not as inherently positive or negative but, rather, as inherently meaningless, or neutral, until a person creates meaning. Thus, the counselor's role in these approaches is somewhere between a midwife and a coach in that they encourage and point the client in the direction of creating meaning in his or her life. Unlike humanists, they do not believe there is some predetermined self that one needs to actualize; instead, one is free to choose who to become, and failing to consciously choose is nonetheless a choice, one that is not likely to have a happy ending. Clients are the ones responsible for finding and/or creating meaning in their lives; the counselor's role is simply to encourage them to engage in the difficult process of recognizing that existence is meaningless until one takes responsibility for one's life and creates meaning. Famous existential philosophers include Søren Kierkegaard, Friedrich Nietzsche, Jean-Paul Sartre, and Albert Camus.

Phenomenology in Action

Most practicing phenomenological counselors in the 21st century draw from both the humanistic and existential traditions when working with clients (Kirschenbaum & Jourdan,

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2005); thus, these three approaches—person-centered, Gestalt, and a counselor may identify more with either a humanistic or an existential view of human nature but generally will be drawn from both views and all three of the phenomenological theories presented in Chapters 6–8. In addition, there are family counseling approaches that are grounded in phenomenology, with Virginia Satir's Human Growth Model, Carl Whitaker's Symbolic-Experiential, and Sue Johnson's Emotionally Focused Couples Counseling (an empirically supported treatment; see Chapter 1) approaches being the most well known (for a full discussion, see Gehart, 2014).

Commonalities Across Humanistic-Existential Theories

These therapies share several common assumptions and practices, discussed in the following sections.

Focus on Subjective Reality

All three approaches are grounded in the philosophical traditions of *phenomenology*, which focuses on *subjective*, *internal* reality (compared with the philosophical traditions of logical positivism that explore *objective*, *external* reality; Rogers, 1951). Simply put, this philosophical position directs the counselor's attention, curiosity, and questions to the client's *subjective*, *internal reality* more so than the external "facts." For example, when a humanistic counselor hears a client state that she is angry, the counselor's focus and questions are directed to the client's internal experience of anger rather than examining the more logical (or illogical) reasons for why she is angry. Thus, the assessments and interventions of these approaches focus primarily on the client's inner experience and inner world more so than the outer world, based on the belief that change is best promoted by attending to the client's inner reality.

Warmth and Empathy

Another hallmark feature of most therapies grounded in phenomenology and humanism is the counselor's expression of genuine warmth and empathy. In the 21st century, most folks who walk into a counselor's office expect the counselor to be "nice" and understanding (Miller, Duncan, & Hubble, 1997, 2004). It wasn't always this way. This new expectation of counselors is directly due to the impact of phenomenologically based approaches to counseling. As most people know, the early psychodynamic and psychoanalytic counselors were *not* warm and fuzzy: they asked patients to lie on couches while they sat behind silently taking notes with a periodic raise of the eyebrow and "veer-rie interezing" (or at least that is the Hollywood version, which is a bit of an exaggeration but makes the point). However, influenced by phenomenological counselors, later forms of psychodynamic counseling encouraged empathy. Additionally, although the first generation of behavioral, cognitive, and cognitive-behavioral counselors put little emphasis on empathy, later generations have also warmed up over the years. It was the humanists, most notably Carl Rogers, who championed the idea of counselors engaging their clients from a position of warmth and empathy.

Rogers didn't advocate these ideas because he thought counselors should be "nice" and because he thought being "sweet" would make clients feel better. No, there is actually a philosophical reason why he did this. He firmly believed that it was only in such a warm, genuinely empathetic environment that clients would feel safe enough to have the courage to (a) identify, (b) experience, and (c) critically reflect on their inner life, namely, their emotional inner experiences. Thus, in humanistic counseling, *empathy is the primary vehicle for therapeutic change*. This is quite different from any other approach that claims to encourage counselors to be empathetic, such as self psychology and new forms of the cognitive-behavioral approach. For the humanist, empathy *is* the mechanism of change. For other counselors who use "empathy," they employ it to develop a relationship in which the client will feel safe enough to *engage in the other mechanisms that promote change*, such as analysis of interpersonal dynamics or thought-stopping techniques.

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Self of Counselor

Another key feature of phenomenologically based therapies is that the self of the counselor is used to promote change. What does that mean? Phenomenological counselors believe that the counselor relates to the patient as a whole, real, unedited person—not from the distant role of a professional. *How* this is done can differ across approaches. For example, person-centered counselors tend to maintain a softer style, while some Gestalt counselors maintain that the counselor needs to be real even with extremely difficult emotions, such as anger, frustration, and boredom as they relate to the client. Thus, both the characteristic softer style of person-centered counselors and the often highlighted dramatic and provocative style of Gestalt counselors come from the same working principle of using the genuine self of the counselor.

The self of the counselor is used to provide clients with both (a) a role model and (b) a genuine person with whom to have an authentic human encounter. By bringing one's full humanity into the counseling process, clients have the opportunity to experience real intimacy and human connection, often in a way that they have never experienced before. This does not mean that the client and counselor are in a fully egalitarian relationship: the client is still the focus of the conversations and process. Counselors, however, listen and speak from the position of another human being who has known suffering and struggle, even if these are never discussed. For lack of a better word (I am from California, after all), the "vibe" in the room is that "I feel your pain" even if the counselor's "pain" is never once mentioned or even referred to.

Self-Actualization and Maslow's Hierarchy of Needs

Maslow (1954) was an early humanist—not a therapist—who described human motivation in terms of a *hierarchy of needs*, including five areas of functioning:

- *Physiological needs:* Breathing, food, sex, freedom from pain
- *Safety needs:* Shelter, financial security, personal safety, health
- *Love and belonging:* Friends, family, community, social connectedness
- *Esteem:* Feeling valued by others and self
- *Self-actualization:* Realizing one's full potential; becoming more and more who one is

SELF-ACTUALIZATION
Morality, Creativity, Spontaneity, Acceptance, Experience, Purpose, Meaning, and Inner Potential.
SELF-ESTEEM
Confidence, Achievement, Respect for Others, The Need to Be a Unique Individual.
LOVE AND BELONGINGS
Friendship, Family, Intimacy, Sense of Connection.
SAFETY AND SECURITY
Health, Employment, Property, Family and Social Stability.
PHYSIOLOGICAL NEEDS
Breathing, Food, Water, Shelter, Clothing, Sleep.
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The first four areas are the most basic needs that must be in place in order for a person to self-actualize, which is the ultimate goal of all humanistic and existential forms of

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therapy; thus, his work is often cited by humanistic counselors. Self-actualization involves a humble acceptance of the positive and negative aspects of being human generally (existential realities) and of who one is individually (subjective reality) coupled with an unstoppable drive to become more fully human, more fully oneself, and more fully alive. Persons who have achieved a high level of self-actualization strive to contribute to the good of humanity, live by clear ethical and moral codes, and do not rely on acceptance from others to approve of themselves.

Person-Centered Counseling

In a Nutshell: The Least You Need to Know

Arguably one of the most influential theories in the field of counseling (Kirschenbaum & Jourdan, 2005), person-centered counseling is a process-focused approach to helping people become more fully themselves. Developed by Carl Rogers (1942, 1951, 1961, 1980)—thus, it is often referred to as Rogerian counseling or its early term of client-centered counseling—person-centered counseling is based on the radical and startling proposition that the necessary and sufficient elements of therapeutic change are (a) counselor congruence or genuineness, (b) accurate empathetic understanding of the client, and (c) unconditional positive regard. Rogers asserted that if these three things were in place, over time clients would become more fully themselves and eventually the problems they came to counseling for would resolve. Person-centered counseling *does not* develop treatment plans to directly address the presenting problems that clients report, such as depression, conflict with a spouse, or indecision with career direction. Instead, the counseling focuses on helping clients to experience their in-the-moment internal experiences to expose the facades they live behind and the socially imposed shoulds that may be organizing their lives. As clients are able to more accurately and deeply experience themselves *while in relationship to the counselor*, they become better at making decisions that need to be made, experiencing themselves more fully and accurately, and relating to others, all of which works together to help them resolve the issues that brought them to counseling in the first place. Thus, techniques are avoided in favor of the counselor promoting a basic process of becoming more fully and accurately aware of one's inner world.

Common Myths

Numerous myths and misunderstanding surround person-centered counseling. So, let's bust a few of those before we go any further:

Myth: Person-centered counselors are "nice" and always work to make the client to "feel good."

Closer to the truth: Person-centered counselors maintain an unconditional positive regard for people while still acknowledging that people make poor decisions, hurt others, and are capable of horrific acts.

Unconditional positive regard is often misunderstood to mean that the counselor never, ever, ever confronts the client on inconsistencies, dangerous decisions, or unrealistic thinking. New counselors further mistranslate unconditional positive regard to simply mean "being nice," in the typical social meaning of the word. Unfortunately, unconditional positive regard is only very loosely related to niceness as most of us think of it. Instead, it has a more spiritual quality: think Mother Teresa or Gandhi-like niceness. Unconditional positive regard is an attitude that focuses on the client's basic human worth at a fundamental level. It also recognizes that humans have free will and that they make bad decisions, have irrational fears, and are capable of hurting themselves and others. In essence, unconditional positive regard involves embracing the whole person—light and darker sides—rather than a Pollyanna "everyone is good; all feelings are good; it's all good" naive approach. Being able to meaningfully embrace clients with

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unconditional positive regard is an idealistic and lofty goal toward which you can spend a lifetime working.

Myth: Person-centered counselors "validate" the client's feelings, always taking the client's side.

Closer to the truth: Person-centered counselors honor and "validate" each person's subjective experience as his or her subjective experience, understanding that it may or may not be closely correlated with other people's experience of the same event.

Related to being nice, many new person-centered counselors hear about "validating" client feelings and translate this as having to always take the client's side on an issue. This is very dangerous because when you are working with an individual client, you are unable to assess or affect persons outside the session. Therefore, if you even give the impression that the other person is "wrong" and the client is "right and justified" in his or her feelings and perceptions, there is very little that is going to change as result of that session. Instead, there is a subtle yet important distinction to be made. Each person has his or her unique experience and emotional reaction to a situation—that much can be validated. However, that does not mean that our emotions are based on any type of accurate perception of others or are based on realistic expectations. I can be upset with my husband for not remembering how I take my tea; that does not mean that those feelings are "valid" in the sense that they are based on realistic expectations and interpretations of others. Instead, I may need to be validated in terms of "yes, this is how I feel," but the counselor's job in this situation would be to help explore where my expectations came from and to help me take responsibility for my half of the interaction.

Myth: One of the most useful techniques is to ask clients, "How does that make you feel?"

Closer to the truth: Asking "How does that make you feel?" implies that the counselor is interested in a person's emotional experience but is unable to accurately identify the client's subjective experience because of a *lack* of empathy.

Second only to traditional analysis on the couch, this is one of Hollywood's favorite ways to mock counselors and the strange things we do. The question "How does that make you feel?" is often used by new counselors trying to use a person-centered approach. The question has its place in this approach and others, but it is *not* a particularly good or key question. Since person-centered counseling posits that empathy is a core condition, *the counselor should have a fairly good idea about how that made the client feel and reflect it back to the client*—hence, the question is rarely needed in this approach. However, when starting out, many new counselors find that they don't have a good sense of how the client might be feeling and use this question to find out. Used too often, more than once per session, the question can quickly become annoying, *especially* because most clients have seen counselors mocked in movies and on television for asking this question.

The Juice: Significant Contributions to the Field

If you remember one thing from this chapter, it should be ...

Core Conditions

The necessary and sufficient conditions of personality change boldly identified by Carl Rogers (1957) are arguably some of the most influential ideas put forth in the field of counseling and psychotherapy (Kirschenbaum, 2004; Kirschenbaum & Jourdan, 2005). Rogers (1957) identifies six conditions necessary for constructive personality change over a period of time:

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. The second person, whom we shall term the therapist, is *congruent* or integrated in the relationship.

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4. The therapist experiences *unconditional positive regard* for the client.
5. The therapist experiences *empathetic understanding* of the client's internal frame of reference and endeavors to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved. (p. 241; emphasis added)

In later writings, these six conditions are boiled down into three conditions that the therapist must create in the counseling relationship:

1. Congruence or genuineness of the counselor
2. Unconditional positive regard
3. Accurate empathy

These three conditions are the heart of person-centered counseling. Rogers (1957) believed these to be necessary and sufficient for personality change regardless of the counselor's theory of choice or the client's presenting problem; he clearly states that this is his hypothesis until empirically proven otherwise. Rogers researched the hypothesis put forth in this article for the following three decades, and many after him have continued to test and refine his hypothesis (Kirschenbaum & Jourdan, 2005). Nonetheless, the debate rages on as to whether his hypothesis is correct (Brown, 2007; Hill, 2007; Kirschenbaum & Jourdan, 2005; Mahrer, 2007; Wachtel, 2007). At present, most would agree that the conditions outlined by Rogers in 1957 are *neither* sufficient *nor* necessary, but there is a substantial body of evidence to indicate that they are clearly *facilitative* and "crucial," meaning that they are *helpful* to *extremely helpful* in promoting change (Kirschenbaum & Jourdan, 2005). Translated even more simply, although there are some documented exceptions, in most cases the conditions identified by Rogers are highly correlated with positive counseling outcomes, *no research has identified a specific population or problem for which these conditions are counter-indicated* (inappropriate). The common factors movement (see Chapter 1) is an outgrowth of the research that indicates that the qualities advocated by Rogers are highly correlated with positive therapeutic outcome, more so than the counselor's choice of theory. To boil it down even further, although they may not be necessary and sufficient for all clients in all cases, they are extremely important for positive outcomes regardless of the counseling theory you choose to work from—so read the following sections closely, as they probably make up the most important part of this book in terms of being a great counselor.

Genuineness or Congruence The first condition is counselor *genuineness* (Rogers, 1957), later referred to as *congruence*, which refers to the counselor's outer expressions being "congruent" with his or her inner experience (Rogers, 1961). In 21st-century vernacular, we call this "being real." However, Rogers is referring to a humanistic, philosophical definition of what it means to be real, whole, and integrated, not what popular culture might define as real. Rogers's definition emphasizes being freely and deeply one's self while able to *accurately* "take in" what is experienced and simultaneously remaining aware of one's internal processing of that experience. Rogers explained congruence stating that "by this we mean that the feelings the therapist is experiencing are available to him [or her], available to his [or her] awareness, and he [or she] is able to live these feelings, be them, and is able to communicate them if appropriate. No one fully achieves this condition, yet the more the therapist is able to listen acceptingly to what is going on within himself [herself], and the more he is able to be the complexity of his feelings, without fear, the higher the degree of his congruence" (Rogers, 1961, p. 61). Thus, congruence and genuineness is an idealized goal to which counselors continually aspire to more fully achieve. Far from an all-or-nothing state of affairs, it is a continually evolving and ever-deepening process.

Another way to understand Rogers's definition of genuineness is to approach it from its opposite, which is playing a role or having a facade (Rogers, 1957), including the role of "professional." Being congruent means that one does not try to "act" professional, "be" helpful, or otherwise take on a role or mask. This is a fine distinction

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because in some ways there are professional boundaries that need to be maintained: this is not a friendship but a helping relationship that has certain legal and ethical constraints. On the other hand, the typical slightly detached professional role, especially at the time Rogers was developing his ideas, is also not appropriate. Much like Goldilocks, there is a place in the middle that is just right—and the actual contours of this middle ground often vary from client to client.

Finally, I should mention that it is very difficult to be genuine in this way when first starting out, simply because the new counselor has too many other things to think about: getting informed consent, conducting a mental status interview, assessing for danger, making a diagnosis, using new interventions, and so on. The more a counselor's mind is trying to remember these things, the less able the counselor is able to be genuine because too much focus is elsewhere. With time, these other tasks become second nature, and it becomes easier to be genuine. Perhaps one of the best indicators that a counselor is being genuine is a pervading sense of inner calm and centeredness, no matter what the client says or does.

Unconditional Positive Regard *Unconditional positive regard* is what it sounds like—valuing your clients no matter what they say or do (Rogers, 1957)—and has also been described as warm acceptance, nonpossessive warmth, prizing, affirmation, respect, support, and caring (Hill, 2007). This sounds a bit like Pollyanna, so let's try to analyze what Rogers really meant by this. The underlying attitude here is not a one-dimensional belief that "all people are good" and that good counselors "love everybody." After all, counselors work with some of the most difficult, angry, and mean people in society: child molesters, criminals, divorcing spouses, gang members, negligent parents, substance abusers, and so on. If you have developed unconditional positive regard based on the Pollyanna notion that all people are good, it is going to fail you with these clients. Instead, unconditional positive regard needs to be built on a more subtle and reflected philosophical premise.

Unconditional positive regard is founded on the idea that we are all human and that we all suffer and therefore have the capacity for good and evil (or destructive behavior if you prefer). If you see yourself as far superior to the pedophile, vengeful divorcee, or gangbanger, you are probably unaware of the darker potentials that lie within each of us. Thus, unconditional positive regard is best motivated by a deep sense of compassion for how hard it is to be human—and for how easy it is to get off track and make bad decisions. When you view clients from this perspective, you can still hold them accountable for their past and current decisions and yet have compassion and hope for their current situation and future.

Accurate Empathy Rogers defines *empathy* as being able "to sense the client's private world as if it were your own, but without ever losing the 'as if' quality" (Rogers, 2007, p. 243). In the practice of counseling, empathy involves not only the ability to accurately perceive the internal world of the client but also the ability to meaningfully share this understanding with the client. Rogers (1957) explains that "to sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it, is the condition we are endeavoring to describe. When the client's world is this clear to the therapist, and he moves about in it freely, then he can both communicate his understanding of what is clearly known to the client and can also voice meanings in the client's experience of which the client is scarcely aware" (p. 243). Doing this requires that the counselor be keenly in tune with his or her internal world while having clear-enough boundaries to perceive how another person's internal world hangs together.

Once the counselor has a sense of what the client *might* be feeling, the counselor then *reflects* this (see below) back to the client to (a) indicate that the counselor has understood, (b) check to make sure the counselor has understood correctly, and (c) provide the client with an opportunity to reflect on his or her internal experience in a slightly different context—namely, in external dialogue in the words of another person. Having one's intimate private world described by someone else is often a profoundly

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moving experience that often transforms one's experience, perception, and/or understanding of one's own experience. *That* is where the counseling comes in. For this reason, the question "How does that make you feel?" (see "Common Myths") is generally not as helpful as being able to convey accurate empathy.

Empathy should be conveyed tentatively, and the counselor should create space in the relationship for the client to say, "No, that is not how I feel," and not get into a tug-of-war over who's right about how the client feels. To be sure, there will be times when the counselor's reflection is accurate and yet the client disagrees for one reason or another. If this is the case, the counselor may want to rephrase it in a less dramatic version (e.g., rather than "You are angry at your mother" to say "You didn't like what your mother said yesterday") and then allow the client to further explore this *at her or his own pace.* The good news about empathy is that you don't have to get it right every time. If you have established a strong relationship and frequently seem to understand, then at the times when you don't, the client feels safe enough to correct you. In fact, when working with clients who tend toward people pleasing, I do not believe a rapport has been established until a client feels safe enough to tell me that I got it wrong. Only then do I know that the client has dropped the people-pleasing facade and feel safe enough to be real with me. All that said, indeed, there are times, once you have a strong rapport, when it is effective to ask that oft-mocked question, "How does that make you feel?"

Cultural and Gender Considerations Although in theory it is simple enough, demonstrating appropriate empathy is far more difficult than it initially sounds because culture and gender greatly affect how one expresses empathy and what a person experiences as empathetic. For example, some people expect heartfelt, warm expressions of empathy: "You feel deeply betrayed by your daughter's choice," while others find such empathetic statements shameful and insensitive because they lose face or think that you are putting words into their mouth. Such persons may experience a subtle or even nonverbal expression of empathy more sincere and meaningful: a silent nod with a look of understanding. Thus, counselors need to become skilled in different ways of conveying empathy. In the case study at the end of this chapter, the counselor adapts the core conditions to work with May, a Taiwanese American woman who is struggling with panic and perfectionism, by using culturally appropriate expressions of emotion.

Measuring Empathy In your practicum class, you may learn about Carkhuff's (1969) five-point scale for measuring empathy. This scale is used in training to help new counselors learn how to refine their empathy reflection skills. The scale is as follows:

Level 1: No empathy: Reflection focuses on content or intellectual part of client message. *Example: You think your daughter made the wrong decision.*

Level 2: Some empathy communicated: Some empathy expressed but some aspects of emotional experience ignored or missed. *Example: You don't like your daughter's decision.*

Level 3: Basic empathy: Reflects client emotion back at the same level that client expressed it. *Example: You are angered by your daughter's decision.*

Level 4: Deepened empathy: Reflects back client emotion at a slightly deeper level than client expressed, providing an enhanced understanding to further the client's exploration of internal process. *Example: It sounds like you are very disappointed and embarrassed by your daughter's decision.*

Level 5: Significantly deepened empathy: Counselor significantly expands and deepens the reflection, identifying subtle emotions that may not have been clearly expressed. *Example: It sounds like you feel betrayed yet also guilty about your daughter's decision.*

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Let me be the first to tell you that every comment you make as a counselor cannot and should not be a level 5. It's impossible (because you need the other exchanges to work up to a level 5), but also you would at best sound loony and at worst be an incredibly annoying conversational partner. Nonetheless, being an eager student, when I trained using this scale, I had the sad misunderstanding that every response should be at a 5. The key thing to remember here is that trying to get to a level 5 statement once or a few times during a single session is an appropriate goal. In fact, all you really need is one level 5 reflection that is truly meaningful to the client—that is all that really needs to happen in a single session for it to be profoundly useful to the client.

Rumor Has It: The People and Their Stories

Carl Rogers

Carl Rogers is widely regarded as the most significant person in the history of psychotherapy: in both 1982 and 2007, *Psychotherapy Networker* readers nominated him by a landslide as the most influential psychotherapist in the United States. He is beloved because he so consistently and unmistakably embodied the warm, caring spirit of which he spoke in writings and demonstrated in his work. He was a truly remarkable man whose influence continues to grow.

Born in 1902 outside of Chicago, he grew up in a conservative, Protestant midwestern family that did not value the expression of emotion (Kirschenbaum, 2004). He entered college, planning to follow in his father's footsteps as a farmer, but soon decided to pursue a career in religion. While studying at Union Theological Seminary in New York, he began taking classes in psychology and then decided to pursue a doctorate in clinical psychology, completing his fellowship at the Institute for Child Guidance. While finishing his dissertation in 1928, he took a position in Rochester, New York, where he spent the next 12 years as director of the Child Study Department at the Rochester Society for the Prevention of Cruelty to Children and then at the Rochester Guidance Center. During this period, he was influenced by students of Otto Rank, who used "relationship therapy" that emphasized patient self-insight and self-acceptance within a therapeutic relationship. In his last years in Rochester, Rogers (1939) wrote his first book, *The Clinical Treatment of the Problem Child*.

Based on the success of this book, he took a full-time professorship at Ohio State University and soon published what was to become a revolutionary book that many considered the launch of the counseling profession: *Counseling and Psychotherapy: New Concepts in Practice* (Rogers, 1942). After four years in Ohio, he took a position at the University of Chicago (1945–1957), where he was able to do more research on his theory, which he then called *client-centered therapy*. In 1957, he moved to the University of Wisconsin, where he had a joint position in the departments of psychology and psychiatry and was able to conduct research on schizophrenia. In 1961, he published what was to be his most popular book, *On Becoming a Person: A Therapist's View of Psychotherapy*.

Wanting to further his research, in 1963 he moved to La Jolla, California, where he took a position at the Western Behavioral Sciences Institute. In 1973, he and others formed their own organization, the Center for Studies of the Person, where he remained for his last 15 years. In California, he expanded his ideas, now called *person-centered therapy*, for working in business, education, group leadership, and other health professions. His student-centered learning theories (Rogers, 1969) have been particularly influential in transforming modern education. In addition, in the last decades of his life, he used his person-centered approach to promote peace and reduce international conflict, working with Protestants and Catholics in Northern Ireland, Blacks and Whites in South Africa, and conflicting parties in South America. Rogers actively worked on the Carl Rogers Peace Project until his death in 1987.

Natalie Rogers

The daughter of Carl Rogers, Natalie Rogers (1997) carried on her father's work, applying his ideas primarily in the area of art and expressive therapies.

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Robert Carkhuff

Carkhuff began his career studying the conditions that were correlated with positive outcomes in therapy, his findings largely in line with those of Rogers (Truax & Carkhuff, 1967). His later work integrated person-centered and behavioral methods to balance "insight" with "action." Carkhuff developed scales for measuring Rogers's core conditions as well as other core conditions that he identified through his research (Brazier, 1996). Because they are more behaviorally defined, Carkhuff's core conditions are frequently used to teach new counselors basic skills.

Big Picture: Overview of Counseling Process

Person-centered counseling is a *process-oriented* approach, meaning that the counselor's attention is on *how* things happen (process) rather than *what* happens (content). As the name implies, the focus is on *persons*—most notably their inner processes—rather than their problems (Rogers, 1961). As a humanistic approach, counselors' primary aim is to help clients become more fully themselves, more authentic, and less attached to social roles and expectations. The person-centered counselor has a strong belief that symptoms will resolve themselves as clients becomes more self-actualized because they will view problems differently and take more responsibility for their emotions and life situations.

The process of self-actualization is not as easy or smooth as it initially sounds. In session, the counselor pays less attention to the content of the client's life—which is almost always less anxiety-provoking to discuss—and instead focuses on *how* the client interacts with self, others, and life challenges: Does the client tend to blame others, or does the client take responsibility for his or her life? Does the client focus on details of external events, or is the client able to identify what is going on within himself or herself? Does the client have realistic expectations of self and others? The process is not always easy, as the counselor will gently "confront" attitudes, beliefs, and inconsistencies that keep the client from becoming more self-actualized. Throughout this process, the counselor gently and consistently redirects the client to more clearly articulate thoughts, feelings, and longings, especially those that may be difficult to admit to self or others, such as embarrassment, anger, shame, resentment, and so on. Through this process, the client begins to integrate contradictory and less-than-perfect parts of the self, reducing defensiveness and increasing his or her openness to experience. The counselor's primary role is to help the client remove the barriers—most of which the client has erected—to his or her own self-actualization.

Rogers (1961) describes seven stages of the change process a person typically experiences from the time of entering counseling to achieving—at least to some degree—self-actualization.

Seven Stages of the Change Process

1. *First stage:* In this stage, a person's personality seems fixed, personal problems are not acknowledged, there is a remoteness of experiencing, and there is little desire to change; the person is not likely to voluntarily enter counseling.
2. *Second stage:* If a person in the first stage is able to feel " received" by the counselor, he or she begins to loosen up and is more open to seeing problems, which are viewed as external to the self ("bad things happen to me"), with little sense of personal responsibility.
3. *Third stage:* If clients continue to feel accepted and understood by the counselor, they become better able to express past feelings and personal meanings.
4. *Fourth stage:* If clients continue to feel safe with the counselor, they begin to become more open to reconsidering their constructs about self and others and are increasingly able to verbalize deep emotions.
5. *Fifth stage:* As clients continue to explore themselves in the safety of the counseling relationship, they are increasingly able to verbalize in-the-moment emotions and experiences, and they have an increasing desire to be the "real me."
6. *Sixth stage:* Rogers describes a distinct shift in the sixth stage, where the person is now able to experience difficult emotions as they arise in the present moment with

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acceptance rather than fear, denial, or struggle.[1] Once this change happens, it tends to be irreversible, meaning that the client will continue to accept even the most difficult emotions rather than deny them.

7. *Seventh stage:* In this stage, it is no longer necessary for the client to be received by the counselor to self-actualize, although it is still helpful because the client has learned how to sustain the process of self-actualization without outside help. This stage generally occurs outside the counseling relationship.

Making Connection: Therapeutic Relationship

Relationship as Change Agent

Unlike most psychotherapies, person-centered counselors view the counseling relationship as the primary vehicle for change—*not* the counselor's interventions. They believe that it is through the authentic, human relationship between the counselor and client that the client is able to progress through the seven stages above and become more authentically themselves (Rogers, 1961). This is different from psychodynamic approaches in which the client is "working through" his or her issues in the therapeutic relationship and the counselor is interacting from a therapeutic role to "repair" and "correct." Instead, the person-centered counselor views the relationship as two authentic humans in relationship; when the client experiences being allowed to be fully himself or herself in relationship, one's inherent tendency to strive for positive growth is activated.

Therapeutic Presence and the Core Conditions

As discussed above—and as we will continue to repeat throughout this section—Carl Rogers (1961, 1980) based his person-centered approach on three counselor qualities used to promote change in clients, the core conditions being: (a) congruence or genuineness of the counselor, (b) accurate empathy, and (c) unconditional positive regard. These are the heart of the counseling relationship, but they are not an end in themselves. They are best thought of as the key ingredients in a chemical reaction that, when mixed together, create something far greater and more powerful than the inert ingredients alone. The result of this chemical experiment in this case is called *therapeutic presence* (Gehart & McCollum, 2008; Geller & Greenberg, 2002; McDonough-Means, Kreitzer, & Bell, 2004). Therapeutic presence is a quality of being, having intrapersonal, interpersonal, and transpersonal elements, including that of empathy, compassion, charisma, spirituality, transpersonal communication, client responsiveness, optimism, and expectancy, making it an elusive and difficult-to-operationalize concept. That said, research indicates that clients know it when they feel it.

Clients tend to accurately sense how much and what type of information to share with counselors based on their quality of presence (Geller & Greenberg, 2002; McDonough-Means et al., 2004). If a counselor exudes even the slightest bit of anxiety while a person retells a tale of sexual abuse or trauma, or of judgment while sharing about a relationship or drinking episode, the client is likely to edit, recast, or simply cut short their relaying of experience. If the counselor is uncomfortable with sharing their emotions about what is going on in the present moment (i.e., immediacy), the client will be, too. As counselors become more experienced in session while also practicing personal reflection and self-care, the quality of their therapeutic presence is likely to become more noticeable and facilitative.

The Viewing: Case Conceptualization

When Carl Rogers talked with people, he didn't just experience unconditional positive regard and empathy. He also carefully observed what they spoke about and how they spoke to assess to what extent they were in touch with their authentic selves.

[1] This acceptance of immediate experience is the goal of mindfulness meditation, which has been most fully developed in cognitive-behavioral therapies discussed in Chapter 9; humanistic therapists also integrate mindfulness to cultivate the type of lived experience described by Rogers in this stage.

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He developed a seven-stage model (Rogers, 1961) that described how he saw people moving along a continuum from a rigid definition of self to a more flowing and ever-changing experience of self. Rather than simply change the definition of self—from one static identity to another—Rogers (1961) came to believe that self-actualization involves a process of letting go of static definitions of self and increasingly embracing a fluid experience of self in lieu of a singular identity.

In the early stages, people are unaware of their feelings, speak more about others than themselves, and often feel more like the victim than protagonist in their life stories. As people experience the effect of the core conditions in the counseling, these things change. People begin to experience their emotions as they are happening in the moment; they are able to readily identify what they are feeling, and they take greater responsibility for what happens in their life and how they emotionally respond. These stages are used to conceptualize where the client is along the continuum of self-actualization. Rogers maintained that people generally hovered around a single stage in all areas of functioning, although minor exceptions may be noted at a particular time or in a specific context. Table 6.1 illustrates the changes as people move through the stages.

TABLE **6.1**
Seven Stages of Rogers's Change Process

	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6	Stage 7
Experience and communication of self	Communication about externals	Able to discuss nonself topics	Expression of self as object; self-experiences as objects	Increased awareness of self	Desire to be "real me"	Self as object tends to disappear	Self as process
Recognition of feeling	Unrecognized or not owned	Described as unwanted or past objects	Little acceptance of feelings	Feelings described as objects in present	Begin owning feelings	Feelings readily accepted	Feelings accepted and owned
Expression of feelings	Little to none	May be exhibited but not owned	Description of feelings	More intense description of past feeling	Expressed freely in present	Full; physical loosening	Full and flowing
Present moment experiencing	Little to none	Bound by structure of the past	Bound by past primarily	Less bound by past, less remote	More immediate but still somewhat surprising	Immediate and rich; process quality; physiological loosening	Immediate and rich in and out of session
Personal constructs	Extremely rigid; black/white	Considered "facts"	Rigid but recognized as constructs	Discovery of constructs	Critical examination of constructs	Dissolve in experiencing moments	Tentatively held
Complexity and contradiction	Unrecognized	Expressed but unrecognized	Recognition of contradictions	Concern about incongruence	Surprise and fright as feelings bubble through; more acceptance	Vividly experienced and dissolve in congruence	Acceptance and ownership of changing feelings
Perception of problems; responsibility for situation	Unrecognized	External to self. No sense of personal responsibility	Personal choices seen as ineffective	Some self-responsibility in relation to problems	Increased responsibility	No longer external or internal; problem not perceived as object	Full responsibility for self and emotions; confident about self as process

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Experience and Communication of Self

As people become more self-actualized, *how* they experience themselves changes. The sense of self evolves from a static entity to one where the self is more of a process that is constantly unfolding and changing. Paradoxically, rather than "discovering" a constant self, a person discovers that the self is constantly in flux and unfolding.

Recognition of Feelings

Rogers theorized that the more self-actualized a person is, the better that person can identify and own emotion. In assessing clients, counselors look for whether clients can identify a range of emotions when they discuss the concerns they bring to counseling. Can they identify feelings of anger, hurt, joy, or fear? In most cases that warrant seeking counseling, a wide range of emotions is present to some degree or another. In some cases, a client has great difficulty identifying any emotion; in others, there is a particular favorite, such as anger or hurt, that is primarily felt. The more self-actualized a person is, the greater the range of emotion and the greater his or her ability to "own" that emotion as one that he or she feels without shame, fear, or embarrassment.

Expression of Emotion

In the process of self-actualization, people become better able and more comfortable with expressing their full range of emotions. Early in the process, people may not express any emotion: they appear almost emotionless and therefore at times appear to themselves and others as having "everything under control." However, that sense of control is extremely fragile. Through the counseling process, people become more aware of their feelings, initially describing them as if they were happening to someone else. As they continue, they become able to describe both past and present emotions fully and in a way that is flowing and natural.

Gender and ethnic background often significantly impact which emotions are expressed and how they are expressed. For example, in most cultures, women are allowed to more freely express emotion than men. All cultures have values related to emotional expression that define where, how, and with whom emotion is best expressed, and also which emotions are socially acceptable in which situation. For example, Japanese culture values emotional restraint in most public settings, whereas Mediterranean cultures, such as the Greeks and Italians, value relatively bold expression of emotion in the same situations. Thus, counselors need to carefully consider gender and culture as well as age and socioeconomic status to fairly interpret a person's emotional expression. In the case study at the end of this chapter, the counselor carefully takes into account norms for emotional expression, the client's level of acculturation, and the client's symptoms when assessing her patterns of emotional expression.

Present Moment Experiencing

Present moment experiencing refers to the ability to mindfully experience emotions in the present moment. When experiencing emotions in the here and now, a person is able to (a) actually feel the emotion and (b) reflectively articulate the emotion (e.g., "I am feeling angry" rather than launch into an angry tirade that blames others). The more a person can experience intense, difficult emotions in the present while still being able to productively talk about them, the greater his or her level of self-actualization. Initially, most clients have little present moment experiencing; most of their experience is related to thoughts and worries about the past or future. Through the counseling process, clients become increasingly able to feel their feelings in the present moment *and be aware of this experience,* experiencing and witnessing their experience at the same time.

Personal Constructs and Facades

Rogers (1961) often described inauthentic living as living behind a "mask," or facade. These facades are the *personal constructs* we use to tell us who we are, how we should behave, and what we are worth. In contrast, authentic living refers to living in the process of being human, accepting the varied flow of experience that cannot be captured by

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a single construct or definition of who we are. For example, if a person maintains the construct that she is a "nice" person, she will have to suppress, ignore, or otherwise disregard the very real and normal human reactions, such as anger, disappointment, boredom, and dislike; she will have to disregard parts of herself, some vital, in order to maintain the facade. Initially, a person's personal constructs are rigid and black and white: *I am X, not Y*. As people become more self-actualized and begin to experience themselves more as an unfolding process than a static entity, these constructs become less and less important, and instead they simply experience themselves as a complex being having a series of unfolding life experiences that involve a fluid and adapting sense of self. In the case study at the end of this chapter, the counselor helps May become less identified with her perfectionist and high-achieving facades, allowing herself to increasingly experience herself as a constantly evolving process.

Complexity and Contradictions

Humanistic counselors also assess for a person's ability to engage the complexities and contradictions that characterize our internal lives and life more generally. We often believe that humans are "logical" creatures that make sense, having singular opinions and emotions that are rational. This is one myth that is quickly busted if you ever decide to practice mindfulness meditation for even 60 seconds. The Buddhists liken the mind to a monkey that jumps from tree to tree, up and down, here and there, in an erratic, unpredictable pattern. The mind similarly jumps from topic to topic, past to future, thought to feeling, without necessarily being consistent or coherent. In fact, the more complex the topic, the more likely a person has contradictory thoughts and emotions: both loving and resenting a significant other, both liking and hating one's career, and so on.

Early in the counseling process, most people are totally unaware of their own contradictory thoughts and feelings. As they become more aware, they become increasingly concerned about the lack of congruence. Rather than "pick a side" and end contradiction, the process of self-actualization moves toward greater acceptance of these contradictions as part of the complexity and "messiness" of being human. The greater a person's ability to accept these inherent contradictions in oneself, others, and life, the more resourceful one will be in managing life stressors.

Perception of Problems and Responsibility

In the early stages, problems are perceived as caused primarily by the outside world: others, circumstances, and so on. As people progress through the stages, there is an increasing awareness of one's responsibility and agency in every situation, and therefore problems are increasingly described with an emphasis on how one is contributing and/or perpetuating the situation. For example, rather than complain that "my wife is always nagging me" or "my husband never helps out around the house," clients increasingly say that the problem is "I have a hard time motivating myself to get things done" or "my expectations are too high for myself and others."

Often in life, it feels like life happens "to us": people do things to make us angry, hurt us, or prevent us from getting what we want. It may be a lover who says something thoughtless, a boss who passes us up for a promotion, or a parent who doesn't have time for us. The more self-actualized a person becomes, the greater the awareness that life is a two-way street. In most cases, how we interact with another contributes to how they respond to us. In all cases, we have control in how we decide to respond in terms of actions, words, and even emotions. When clients describe the problems in terms of being agents of their own lives, they take responsibility for their part in creating the problem situation and are quick to assume full responsibility for resolving the problem, no matter the source. In contrast, clients with lower levels of agency tend to feel victimized and often are mystified about how to go about solving problems.

Peak Experience and Flow

Rogers describes the self-actualized self as "fluid" and "flowing." Recent positive psychology researchers also describe peak experience as a *flow* state, a unique quality of experience in which a person feels fully present, in sync, and immersed in a challenging

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activity for which one has sufficient skill (Carr, 2004). Typically during flow experiences, time seems to be moving more slowly, and activity seems to happen without effort or thought. A classic example is the football quarterback making a seemingly impossible pass to another player; often, when interviewed afterward, the athlete will describe the event as though he, the ball, and the receiver were one. Other common flow experiences involve playing music, cooking, writing, running, dancing, and similar activities. Flow experiences typically are associated with activities that require effort and practice. After a certain level of mastery, the activity takes on an effortless, automatic, and fully alive quality for distinct periods of time. These are a type of peak experience associated with the humanistic view of being self-actualized. Counselors can ask about the frequency and quality of these flow experiences in assessing a client's level of functioning. For example, depression is typically an experience in which there are few, if any, experiences of flow; as people begin to recover, they often find that flow experiences return.

Targeting Change: Goal Setting

Self-Actualization: "Becoming That Self Which One Truly Is"

It's easy to write the final goal on a person-centered treatment plan because the overarching goal in person-centered counseling is consistent with most other humanistic approaches: to promote *self-actualization.* Self-actualization refers to fulfilling one's potential and living an authentic, meaningful life, or, as Rogers (1961) explains, "to be that self which one truly is" (p. 163). Self-actualization is correlated with Rogers's (1961) Stage 7 level of development. Unlike existentialists, Rogers firmly believed that humans *naturally* tend toward positive, prosocial growth; the counselor's primary job is to provide the correct environment that fosters this growth (i.e., the core conditions). Maslow (1954) also identified self-actualization as the highest order in his hierarchy of human needs, coming only after more basic physiological, safety, social, and self-esteem needs are met.

Self-actualization (Rogers, 1961) is characterized by the following:

- Openness to present moment experiencing of emotions
- Trust in self
- Internal locus of evaluation and control
- Living without roles, facades, shoulds, or social expectation
- Being a complex, dynamic, and unfolding process (rather than a static entity)
- Openness to experience
- Acceptance of others

Self-actualization is always a long-term, late phase goal: the broad, overarching direction for counseling. Unfortunately, it is a vague goal unless smaller goals that address impediments are used in the middle phase.

Process Goals

It's well established that self-actualization is a *big* goal. However, most of the work in counseling occurs in smaller goals along the way that address *process* issues: a person's internal process. Here is where your case conceptualization comes into play. You can identify areas of growth and turn these into middle phase goals. For example, if a woman describes her life as unfairly limited by all the things she *should do* to be a "good wife," counselors write a goal to "increase living by conscious choice rather than a list of shoulds." Similarly, if a man reports wanting to constantly please others to his own detriment, a process goal would be to "reduce attempts to please others in ways that are detrimental to personal needs."

Example of goals related to specific areas of functioning:

Emotional Expression and Here-and-Now Experiencing

- "Increase ability to identify emotions in present moment."

(*continued*)

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Victimization and Experience of Problems

- "Increase sense of responsibility for own problems and their resolution."

Agency

- "Increase sense of agency and proactive behavior in work life."

Facades and Masks

- "Reduce use of facades in personal relationships to increase experience of intimacy."

Peak Experience and Flow

- "Increase frequency of peak experience and flow in work life."

Perfectionism and Unrealistic Expectations

- "Increase ability to set realistic expectations for self and other to increase acceptance."

Trust Self

- "Increase ability to trust the evolving and changing nature of the self."

The Doing: Interventions

Self of the Counselor and the Core Conditions

The fundamental "instrument" of intervention in person-centered counseling is the "self" of the counselor; the counselor's way of being in the world. It's hard to get more nebulous than that, so you will find a list of other "techniques" in the rest of this section that are all trying to cultivate this one essential instrument of change: the counselor. As a highly relational form of counseling, person-centered counseling relies on the personhood of the counselor to bring a quality of presence that helps clients to transform and become more comfortable with experiencing their authentic selves. In a smaller nutshell, the self of the counselor is the vehicle through which the core conditions are established. Thus, in many ways, the crux of change in person-centered counseling is the quality of the relationship between the counselor and counselee.

In practical terms, using the self of the counselor could involve a wide range of activities, including expressing empathy, using humor, and self-disclosure. What is demanded of the counselor changes depending on the client, the problem, the topic of conversation, and the goals for counseling. Ultimately, it is the clearly communicated authenticity of the counselor that sets the stage for clients to identify, explore, and freely express their authentic selves. Knowing how to use one's personhood to facilitate authenticity in others requires significant maturity, self-awareness, and reflection on the part of the counselor: you can't learn it from a book or by practicing deeper levels of empathy. It's a way of being that takes time—and an excellent supervisor—to cultivate.

Focused Listening or Attending

"Very early in my work as a therapist, I discovered that simply listening to my client, very attentively, was an important way of being helpful. So when I was in doubt as to what I should do in some active way, I listened" (Rogers, 1980, p. 137). This is an excellent piece of advice that is useful not just in counseling contexts but also in most every sphere of life: *when in doubt, listen.* Still not sure? Listen some more.

One of the first skills new counselors learn is listening. Listening in person-centered counseling has a very specific form based on its philosophical foundation in phenomenology. As you might remember from the beginning of the chapter, phenomenology encompasses the study of the internal, subjective world. Thus, when a person-centered counselor listens to clients share their stories, they are listening for and attending to

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descriptions of the persons' *internal world*, most notably their emotions and logic that connects this affective inner world. For example, if a woman begins to describe how she no longer feels loved by her husband, the counselor does not focus on what the husband is doing, what she can behaviorally do differently, or how she could reframe what is going on. Instead, the counselor is curious about the contours of her internal life. Does she feel betrayed, hopeless, rejected, ugly, angry, or sad? The counselor listens for a rich and nuanced description of her internal emotional experience and selects these descriptions to comment on or ask about.

Summarizing

For those of us who expect life to be hard and difficult and who may also assume that "great counseling" must be hard, summarizing as a counseling intervention can be difficult to understand. How can simply restating what a person has just said be helpful and worth paying for? Basically, most of us aren't listening carefully when we speak; even if we are, it sounds very different when someone else says it, especially if it is about a difficult topic. For example, many people frequently make fun of themselves or put themselves down. But when someone else says the same thing—or simply agrees with what was just said—they feel offended, hurt, or angry. That is the same principle at work when summarizing. When counselors paraphrase back the essence of what a client just said, it helps clients to hear what they said in a different way. In most cases, it hits home harder than when they said it themselves. When another person skillfully summarizes emotionally difficult material, clients often hear and feel things in a new way: the reality of a situation often comes into bold relief.

For summarizations to be effective, they need to be (a) well timed, (b) about emerging insights (not just anything the client says), (c) in the client's language, and (d) not biased by the counselor's values, assumptions, or desires. For example, if a woman is going on about all the ways she is not happy with her boyfriend whom she was planning to marry, and states that she knows the relationship is doomed, she is likely to find a summarization from a counselor helpful in crystallizing her insight: "Even though you initially thought he was the one you would marry, you have begun to realize during the events of the past few months that this relationship will not work for you long-term." If the client is struggling against this reality, it can help to recast the summary in the form of a question: "It sounds like you are beginning to question whether this relationship will work for you based on the events of the past few months?"

Try It Yourself

Find a partner and take turns practicing summarizing. Share what it is like to have someone else describe your experience in their own words.

Clarifying

Similar to summarizing, clarifying statements and questions are not glamorous. They seem so simpleminded that you sometimes wonder if it is worth asking. Nonetheless, clarifying questions are some of the most important because often what seems simple and obvious is not. Just as the name implies, clarifying questions involve querying clients to provide more detail or explanation about what they are talking about. Clarifying questions can be categorized into two types, with each playing an important role. The first type of clarifying questions addresses factual issues: who, what, where, and how. These clarifying questions are not considered therapeutic in and of themselves in person-centered counseling, and if overused they actually distract from the counseling process. However, these can be important questions, especially when working with persons from diverse backgrounds. Counselors use fact-focused clarifying questions to ensure that they understand the basic information that makes up the client's experience. These questions help counselors avoid bias by ensuring that they don't project their assumptions onto clients. These questions help clients share their story: Who else was there? When did this happen? What happened next?

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The other type of clarifying questions focus on the client's emotional process. These questions help the client more clearly articulate and conceptualize their internal process and are essential in promoting self-actualization. These clarifying questions are used to help the client more deeply probe and explore their internal emotional life. For example, "You say you are 'upset.' Can you say more about what you mean by this?" Or, "There is a lot to be sad about in this situation, can you share what saddens you the most?" These questions help clients sharpen their ability to identify, name, and share their emotions and thereby better understand and accept their inner life.

Reflecting Feelings

One of the most readily identifiable things that a person-centered counselor does, *reflecting feelings* refers to identifying feelings that the client just described or that seem to underlie what the client just said. For example, if a client complains about an incident at work, rather than focusing on who did what to whom, the counselor listens for the client's emotional experience, which may be one of being betrayed, taken advantage of, or of loss—or even all three. This technique highlights and amplifies clients' awareness of their emotions, reactions, and feelings so that they can more consciously experience them. This technique is especially useful in the earlier stages of actualization when emotions are more difficult to identify, access, and experience. Even with clients who are skilled at identifying their emotions, having another person describe your emotional state can be a powerful experience that provides new experiencing and insight into one's subjective experience.

Try It Yourself

Find a partner and take turns discussing a current struggle. Try to reflect the feelings in your partner's story. Share how it felt to have someone else identify your emotional experience.

Process Questions

Process questions refer to questions or comments that direct clients' focus toward their inner process rather than on content. In everyday conversation, people tend to ask follow-up questions about the content of what happened: who said what to whom when. The conversation stays at a more factual-level description of what happened. Speculation as to why things happen distracts from a client's inner process. In contrast, counselors use process questions to help clients focus on the inner experience, emotions, and subjective reality—broadly speaking, to get them out of their heads and into their heart and bodies. Thus, the focus is on inner *emotional process* rather than factual description or rational analysis of what happened. Process questions can include the following:

- Can you describe what was going on inside of you when you heard the news?
- When you heard the door shut, what was going on inside for you?
- As you are telling me the story now, what types of feelings are coming up? Are these the same or different from what you experienced when things were happening?

Carkhuff's Core Conditions

Robert Carkhuff (1969, 2000; Truax & Carkhuff, 1976) extended Rogers's research by studying the observable and measurable behaviors that facilitated change in counseling. Researching a variety of facilitative conditions, Carkhuff identified several core conditions that are often used to help new counselors develop basic counseling skills. They include the following:

- Empathy (similar to Rogers's accurate empathy)
- Authenticity and genuineness (similar to Rogers's authenticity)
- Respect (similar to Rogers's unconditional positive regard)
- Concreteness and specificity

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- Self-disclosure
- Confrontation
- Immediacy

As the first three have been discussed at length earlier, we will just focus on the last four here.

Concreteness and Specificity

Carkhuff identified concreteness and specificity as counselor behaviors that facilitate the counseling process. Counselors demonstrate concreteness and specificity with questions and statements that help clients to clarify what is vaguely expressed. For example, to describe oneself as "upset" is really not saying much. For some this means to feel angry, others sad, and yet others anxious. Similarly, to say that "my mother's death made me sad" is also quite vague if it isn't followed up with more; such a major loss can be sad in many different ways. Counselors can help clients increase their inner awareness by asking questions that help them to be more concrete and specific about their subjective experiences.

Self-Disclosure

Self-disclosure is a bit like saffron. One of the most valued spices, in large quantities or in the wrong dish, saffron is a culinary disaster that cannot be fixed. So, too, is self-disclosure in counseling. It is so difficult to get right that I often caution new counselors to not use it until after their first year of training. This is not always possible and in some senses is impossible if you take into account that wearing a wedding band, your style of clothes, and your choice of mobile phone are all forms of disclosure at some level. However, what person-centered counselors more generally refer to as self-disclosure involves sharing *relevant* personal experience—generally personal struggles that are similar to what the client is dealing with—with the client *for the sole purpose of helping the client achieve their goals.* Self-disclosures may serve several clinical purposes: providing a role model, offering hope, or normalizing the client's experience. All of these are valid uses of self-disclosure and are highly effective when used with the right person at the right time. *However*—and this is a big however—when used at the wrong time with the wrong client, the damage done to the therapeutic relationship is often irreparable because once you reveal personal information, it cannot be taken back or undone. If there is a miscommunication, that can be cleared up. But if your client begins to doubt your credibility, was offended in some way, or has any of an infinite number of interpretations, it may be difficult or impossible to repair the counseling relationship, greatly reducing the chance of a positive outcome. Thus, self-disclosure requires excellent judgment in determining what will be most helpful to clients.

Confrontation

One of the more often misunderstood techniques, affective confrontation—especially when done in person-centered counseling—is not a harsh, critical confrontation but rather the counselor's effort to address discrepancies in verbalizations, perception, and/or body language. In the first case, the counselor points out that what the client just said does not jive with what was said earlier, either in this or another conversation: "you are saying now that you don't care, but earlier you said you were angry." The counselor may also point out discrepancies in terms of how another person is "all to blame" and the client an innocent victim in a situation where each played a part: "you say you don't like how your husband spoke to you; can you also describe how you spoke to him?" Alternatively, the counselor can comment on how the client's body language (e.g., on the edge of tears) is not congruent with what the client is saying (e.g., "I'm fine"). The spirit of these confrontations, unlike Gestalt, is generally one of curiosity and support rather than challenge.

Immediacy

"Immediacy" refers to the condition whereby counselor and client are able to discuss the client's immediate emotional state, which can be related to (a) an outside topic,

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(b) in-session behaviors, or (c) the counselor–client relationship. The ability to feel and immediately reflect on and discuss the emotion of the moment is considered a higher-ordered level of emotional expression and a sign of increasing levels of self-actualization, the ultimate goal of counseling. Counselors can facilitate immediacy in several ways. One is to comment on an emotion that the counselor can clearly observe: "It seems as though you were offended by the comment I just made." Alternatively, counselors can prompt clients to try to identify what they are feeling in the moment: "What emotions are you feeling as you tell me about the car accident you saw on the way to the appointment *or* as we discuss your thoughts about ending the marriage?" Immediacy is intense and intimate and thus must be used with caution. The client can feel put on the spot, attacked, or belittled if the counseling alliance isn't strong enough. It is not a technique to use frequently in most cases—even once a session can be too much for some clients. Additionally, it must be well timed, in a moment where the client is open to feeling vulnerable and exposed. In the case study at the end of this chapter, the counselor uses immediacy often with May to create opportunities for her to experience her authentic self in relation to another.

Try It Yourself

Find a partner and use immediacy to share your present emotional state; if possible, describe how you are experiencing your partner right now in the present moment.

Focusing

Gendlin (1984; see also Gendlin, Beebes, Cassens, Klein, & Oberlander, 1968) developed a technique called *focusing* to help clients more quickly access their emotions. The technique involves directing clients to identify *preverbalized* experience, which may be in the body or otherwise brought into awareness. Then clients are encouraged to carry it forward by bringing close attention to it, describing the experience with words, and then moving into action.

What Person-Centered Counselors Do Not Do

Often, effective counseling is more about what you don't do than what you do do. In person-centered counseling, it is particularly important that counselors avoid doing the following, as each of these prevents clients from engaging their inner process:

- *Using reassuring cliches:* "In the end, it will all be okay" or "There are people in far worse situations" rarely make anyone feel better. As you probably know from firsthand experience, having someone offer such cliches usually incites ire rather than comfort. However, even worse for the person-centered counseling process, this externally offered reassurance cuts short the internal process that a client needs to master to self-actualize.
- *Giving advice:* Another tempting but unhelpful response in person-centered counseling is advice giving. Most clients want advice. In some cases, that is all they want and are frustrated if you don't offer it. However, person-centered counselors are resolute in not giving it but rather in encouraging clients to look inward to find their own inner advice and answers. That said, when working with culturally diverse or immigrant clients, counselors may need to consider whether certain forms of advice or education might be appropriate given clients' expectations and needs.
- *Requesting an explanation:* Phenomenology is at its core descriptive: seeking a description of a person's subjective, internal experience. The counselor's attention is on getting a better, richer description of the emotional terrain of this inner world rather than a logical explanation for how the pieces fit together. The dogged focus on describing the emotional terrain, which requires a particular state of mind, is quickly derailed by requests for information. To use pop psychology lingo,

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person-centered counseling is a "right-brain" activity; asking for explanations is a "left-brain" intrusion into this process.

- *Agreeing with the client:* Ahh! This is one of the most common traps for new counselors. Don't clients need their counselors to "support" them by agreeing with their perspective? I could do a whole chapter on the dangers of agreeing with clients—although there are some rare instances where it does help—but much like counselor self-disclosure, it is more likely to backfire.

  So, let's review some of the many ways this seemingly friendly, kind, and benign act can halt progress or worse. First, when counselors agree with clients, they end the clients' internal dialogue and struggle to answer their own questions and quickly derail the clients' ability to develop their internal locus of control, which is correlated with both self-actualization and long-term happiness. Second, clients often change their opinion and feelings over the course of treatment, if not mid-session, because, in fact, most of us have conflicting emotions about most everything (see "Complexity and Contradictions" earlier). This problem is most apparent when working with women who are being abused by their partners; part of the logic of these relationships is that a person has extreme variability in their feelings toward the abusive partner; thus, one week she wants to stay, and the next she wants to leave. If a counselor takes a side, then the client is less likely to speak up when feelings change. Third, when describing another person or situation, clients—like all of us—see the situation from their perspective. However, by subtly or directly "agreeing" with your clients about how "unfair" a situation is or how wrongly they were treated, you undermine the process of self-actualization that involves taking greater responsibility and accepting others. In short, agreeing with clients is a slippery slope that gets you farther away from the desired goal.
- *Disagreeing with the client:* It is perhaps easier to understand why you don't want to disagree with clients. On one level, it generally does not help convey a sense of empathy. But, more important, counselors avoid disagreeing for the same reason they avoid agreeing: it circumvents the more critical inner process of self-reflection that is ultimately the goal of person-centered counseling.
- *Giving approval:* Giving approval is another tricky situation in counseling. Often you will hear counselors say, "I gave her permission to have her feelings" or "I validated her feelings." *Validation* and *giving permission* can involve a variety of subtle but important differences. Obviously, counselors should not be in the business of "giving approval" for actions or feelings. They have no special sanction from God, the president, or anyone else to determine what is acceptable and what is not. Similarly, if a counselor "validates" a client's emotion or "gives a client permission" to have an emotion, this too can undermine the process of self-actualization if the client uses the counselor to "be okay with" his or her emotions, behaviors, and/or decisions. Instead, counselors want to be careful to encourage clients to validate their own emotions and to give themselves permission to feel what they feel rather than rely on an external source to do that. That is the goal. However, in certain circumstances, particularly early in treatment, clients might need a counselor to help them with this process. Nevertheless, the goal should always be to encourage clients to determine the value and appropriateness of their own emotions rather than look to the counselor for approval.
- *Expressing disapproval:* Similar to disagreement, counselors avoid expressing disapproval because it undermines the client's autonomy in the same way that offering approval undermines it. Even in circumstances—or especially in circumstances—where a client is not engaging in socially expected behaviors, such as an affair, physical violence, or abusing substances, and the counselor refrains from expressing disapproval, the client will be more likely to express disapproval and a desire to change. If the counselor is the first to propose that change is necessary, clients tend to resist more, even if they agree, because they do not have ownership of that idea.

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Interventions for Special Populations

Nondirective Play Therapy

One of the more popular forms of play therapy, Virginia Axline's (1989) nondirective play therapy is based on Rogerian counseling principles. Axline's play therapy is ideally conducted in a dedicated play therapy room that has possibilities for playing with art media, dollhouses, puppets, dress-up, games, sand tray, and other play therapy equipment. In this setting, the counselor allows the *child to lead the play* by choosing activities. The counselor interacts with the child throughout the play to reflect feelings and inner processes.

Eight Principles of Axline's Play Therapy Using humanistic principles, Axline (1989) identifies eight principles of nondirective play therapy:

1. The therapist must develop a warm, friendly relationship with the child in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognise the *feelings* the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behaviour.
5. The therapist maintains a deep respect for the child's ability to resolve his own problems if given an opportunity to do so. The responsibility to make choices and to institute changes is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognised as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (pp. 73–74; emphasis in the original)

Axline readily admits that this approach is not a panacea that will work with all children all the time. Moreover, effectively establishing such a relationship is not an easy task, and counselors will need to work hard to be successful. Nonetheless, Axline's methods are still widely used, particularly with kids who have experienced trauma, abuse, or loss and/or are experiencing internalizing symptoms, such as depression, grief, or anxiety. Gary Landreth and his colleagues (Bratton, Ray, Edwards, & Landreth, 2009) have continued the development of humanistic therapies with children in their model of *child-centered play therapy*.

Expressive Arts Therapy

Natalie Rogers (1997), Carl Rogers's daughter, applies the principles of person-centered counseling to artistic expression with children and adults. Her methods help people access deep emotions that may be difficult to put into words, either because they are not fully in consciousness or because they are too multifaceted to capture in language. She builds on her father's work by creating (a) a psychologically safe environment and (b) a psychologically free environment, namely, the counseling relationship. Natalie believes that a third element is also necessary to foster personal growth: stimulating and challenging experiences, which she provides through opportunities for spontaneous creative expression. Her work is based on some of the following principles:

- All people have an innate ability to be creative.
- The creative process is healing. The expressive product supplies important messages to the individual. However, it is the process of creation that is profoundly transformative.
- Personal growth and higher states of consciousness are achieved through self-awareness, self-understanding, and insight.

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- Self-awareness, understanding, and insight are achieved by delving into our emotions. The feelings of grief, anger, pain, fear, joy, and ecstasy are the tunnel through which we must pass to get to the other side—to self-awareness, understanding, and wholeness.
- Our feelings and emotions are an energy source. That energy can be channeled into the expressive arts to be released and transformed.
- The expressive arts—movement, art, writing, sounding, music, meditation, and imagery—lead us into the unconscious. This often allows us to express previously unknown facets of ourselves, thus bringing to light new information and awareness.
- Art modes interrelate in what I call the Creative Connection. When we move, it affects how we write or paint. When we write or paint, it affects how we feel and think. The Creative Connection is a process that brings us to an inner core or essence that is our life force energy.
- A connection exists between our life force—our inner core, or soul—and the essence of all beings.
- Therefore, as we journey inward to discover our essence or wholeness, we discover our relatedness to the outer world. The inner and outer become one (N. Rogers, 1993, p. 30).

Putting It All Together: Person-Centered Case Conceptualization and Treatment Plan Templates

Theory-Specific Case Conceptualization: Person-Centered

Use the prompts below to develop a theory-specific case conceptualization; the case study at the end of the chapter provides an example.

Describe client's areas of functioning based on the Rogers's stages of change process:

- *Stage of Change Process:* Describe client's approximate stage in the change process (Stages 1–7).
- *Experience of Problems:* Are problems perceived as internal or external (caused by others, circumstance, etc.)?
- *Agency and Responsibility:* Is self or other discussed as agent of story? Does client take clear responsibility for situation? Does client frequently describe self as victim of others or life?
- *Recognition and Expression of Feelings:* Are feelings readily recognized, owned, and experienced?
- *Here-and-now Experiencing:* Is the client able to experience full range of feelings as they are happening in the present moment?
- *Personal Constructs and Facades:* Is the client able to recognize and go beyond roles? Is identity rigid or tentatively held?
- *Complexity and Contradictions:* Are internal contradictions owned and explored? Is client able to fully engage the complexity of identity and life?
- *"Shoulds":* Is client able to question socially imposed "shoulds" and "oughts"? Can client balance desire to please others and desire to be authentic?
- *Acceptance of Others:* Is client able to accept others and modify expectations of others to be more realistic?
- *Trust of Self:* Is client able to trust self as process (rather than a stabile object)?

Treatment Plan Template: Person-Centered

Use this treatment plan template for developing a plan for clients with depressive, anxious, or compulsive types of presenting problems. Depending on the specific client, presenting problem, and clinical context, the goals and interventions in this template

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may need to be modified only slightly or significantly; you are encouraged to significantly revise the plan as needed. For the plan to be useful, goals and techniques should be written to target specific beliefs, behaviors, and emotions that the client is experiencing. The more specific, the more useful it will be to you.

Treatment Plan

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration*: [Describe how you will specifically adapt your approach to be sensitive to client diversity when developing the counseling relationship; this may include respecting cultured and gendered norms for emotional expression.]
   Relationship building approach:
   a. Use **unconditional positive regard**, **accurate empathy**, and **genuineness** to establish the necessary conditions for change.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Carefully adapt assessment for cultural and gender norms for expression of emotion and self-constructs.
   Assessment strategies:
   a. Assess for ability to identify, express, and experience **emotions** in **present moment**.
   b. Assess for ability to experience self as an **unfolding process**, accept proactive **responsibility** for problems, embrace **complexity** and **contradictions**, and experience flow.

Initial Phase Client Goals

1. *Decrease* experience of overwhelming **emotions** and sense of helplessness to reduce [specific crisis symptoms].
   Interventions:
   a. Help client **identify**, own, and **accept emotions** underlying crisis behaviors.
   b. Help client develop a proactive and **competent sense of self** in relation to **complexity** and challenge that underlie crisis.

Working Phase of Treatment

Working Phase Counseling Tasks

1. *Monitor quality of the working alliance. Diversity consideration:* [Describe how you will adapt relationship and monitoring of relationship to be responsive to gender and cultural forms of emotional expression, independence, and communal values.]
   Assessment Intervention:
   a. Assess for client's ability to **express self genuinely** and constructively disagree with counselor; Session Rating Scale.

Working Phase Client Goals

1. *Increase* ability to **recognize** and constructively **expression emotions** to reduce [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. **Empathetically reflect** unacknowledged feelings that are difficult for the client to express.
   b. Assist client in experiencing emotions in the present moment using **immediacy**.

(*continued*)

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2. *Increase* ability to recognize **authentic self** without **facades** to reduce [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. **Process questions** to enable client to clarify inner experience of self.
   b. **Immediacy** to help client experience self in relationship to counselor.
3. *Increase* ability to view self as **responsible** for problem situations and **active agent** in making changes to reduce [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. **Confront contradictions** related to powerlessness and victim thinking.
   b. **Immediacy** to help client experience sense of agency in counseling relationship and present experiences.

Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity consideration:* [Describe how you will access resources in the communities of which they are a part to support them after treatment ends.]
   Intervention:
   a. **Process questions** to help client identify how best to manage potential future challenges; terminate only after client has developed ability to reflect on self without assistance.

Closing Phase Client Goals

1. *Increase* ability to experience **self as an unfolding, evolving**, and **complex process** without holding on to **personal constructs** to reduce potential for relapse in [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. **Unconditional positive regard** to enable client to also accept all elements of self.
   b. **Process questions** with **immediacy** to facilitate experience of self in the here and now.
2. *Increase* ability to **authentically communicate self** with others while simultaneously respecting and enabling the other to also be fully themselves, to reduce potential for relapse in [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. Relate to client using **genuineness and authenticity** to create context in which it is safe for client to do the same.
   b. **Immediacy** of how client is experienced by counselor in session to enhance ability to effectively relate to others as an authentic self.

Tapestry Weaving: Working with Diverse Populations

Cultural, Ethnic, and Gender Diversity

Used with a wide range of clients, humanistic-experiential approaches value clear, congruent emotional expression and the willingness to be vulnerable. Therefore, when working with populations that have different attitudes toward emotional expression and/or you are in a treatment context where such vulnerability feels unsafe, counselors need to proceed thoughtfully. For example, the emotional expression often promoted in the experiential approaches may not be comfortable for some men or East Asian Americans (Wang, 1994), populations that generally value less expressive and more indirect emotional expression; thus, they should be used with caution. That said, one recent

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study found that expressive writing was found to be beneficial for most people but especially those of Asian origin (Lu & Stanton, 2010). Similarly, in another study both Asian and female college students rated experiential therapy approaches more positively than cognitive-behavioral or psychodynamic (Yu, 1998).

Culturally Competent Person-Centered Counseling

Based on his careful review of literature on person-centered therapy with diverse clients, Quinn (2013) hypothesizes two specific adaptations are necessary to provide culturally competent person-centered therapy:

- Counselor congruence with the client's illness myth (i.e., belief or theory about the problem)
- Counselor empathetic understanding of the client's perceptions of and attitude toward the counselor

The first, understanding the client's illness myth—which is a mental health disorder in dominant Western discourses—involves both a) having an awareness of and familiarity with the common cultural beliefs from the client's background (not client-specific), and b) listening carefully for the client's personal interpretations of the problem situation (client-specific). This occurs through a recursive process of frequently checking the accuracy of the counselor's understanding with the client. When the counselor maintains a nonjudgmental stance and unconditional positive regard for the client, this exploration allows for counselor congruence with the client's illness myth.

The second adaption is more challenging. Multicultural clients, especially those with less acculturation, may be slower to trust expressions of "genuine caring" from a counselor. The task of the person-centered counselor is to tolerate the ambiguity of allowing trust to build cross-culturally rather than switch to a more directive style, which would be less anxiety-provoking for both parties. Thus, when the counselor perceives reticence or other hesitation on the part of the client, the counselor empathically and nonjudgmentally responds:

> "I would like to hear about you, but I suspect that it may be hard to trust me with certain things. You may not think I will be able to understand; that is a fair and reasonable concern to have. In fact, I might not. But I can assure you that I want to not only understand you but be helpful to you. I am willing to take this at a pace that feels comfortable for you."

By using the facilitative conditions, the person-centered counselor allows for trust to build across cultural differences to safely emerge for clients in a form and pace that is right for them.

Gender

In addition to cross-cultural differences, emotional expression is also a concern related to client and therapist gender. In particular, counselors need to critically examine their expectations for client emotional expression based on client gender. In one study, nontraditional female clients who had experience with both male and female counselors reported that they believed female counselors expected them to express their emotions in a particular gendered way. These clients felt judged and misunderstood by female counselors because they did not subscribe to stereotyped modes of gendered emotional expression (Gehart & Lyle, 2001). Male clients in the same study reported feeling safer sharing more vulnerable emotions with female counselors. Both male and female clients reported feeling male counselors were more interested in solutions and practical matters than emotions. Thus, with same-gendered and opposite-gendered clients, counselors need to be aware of how cultural norms for emotional expression potentially shape or impede the humanistic-experiential counseling process. Therefore, as part of working sensitively with gender, counselors should be careful to a) avoid inaccurate assessment due to different cultural and gender norms and values concerning emotional expression, b) adjust the level of intimacy in the therapeutic alliance to fit with the client's level of comfort, and c) choose interventions that actively engage clients at their comfortable level.

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Sexual Identity Diversity

Grounded in their values of authentic self-expression, humanistic-existential counselors avoid conceptualizations of sexuality that are based on norms and performance (Kleinplatz, 1996). Thus, humanistic-existential approaches have been widely used with lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) clients (Davies, 2000). The phenomenological emphasis on describing subjective, lived experience and on avoiding pathologizing make humanistic-existential counseling approaches a viable option for LGBTQ clients (Milton, 2000). More specifically, the coming out process can be viewed as a critical part of the self-actualizing process and desire for congruence described by Rogers and other humanists (Beane, 1981; Davies, 2000).

Within the humanistic counseling community, there has been debate about what it means to be a "gay affirmative therapy" (Milton, 2000; Langdridge, 2007). Ethically affirmative, the "weaker" form of gay affirmative therapy, honors the lived realities of LGBTQ clients using a fundamental phenomenological and humanistic approach (Milton, 2000). In contrast, the stronger form, simply referred to as gay affirmative, involves certain prescribed views and practices on the part of the counselor, including advocacy and positive affirmation to directly ameliorate the effect of society's heterosexism. Although this advocate stance is well intended, it is ultimately an expert position, one that does not privilege the client's lived subjective experience but rather foregrounds political and societal realities. Thus, gay affirmative humanistic counselors must strive to carefully balance working within the client's subjective worldview (a more "pure" humanistic approach) with addressing and potentially countering strong internalized messages of heterosexism while working within the assumptions of the model (a more political activist position).

When considering the experience of LGBTQ clients, humanistic counselors can choose to focus on the burden of societal rejection of the client's authentic self and help clients move toward finding safe ways and contexts to express their true selves (Pachankis & Bernstein, 2012). Humanistic counselors should also consider how clients' social contexts may seriously constrain their communication styles, both in their intimate relationships, with supportive versus nonsupportive family members, and with colleagues and strangers. Experiential practices, such as Virginia Satir's Parts Party and family reconstruction (a humanistic family therapist), have been used in gay and lesbian group programs to allow them to reexperience support and their family-of-origin relationships in new and more empowering ways (Picucci, 1992).

Research and the Evidence Base

Carl Rogers (1961, 1981) was a leader in psychotherapy and counseling research. He developed person-centered counseling based on extensive and ongoing research. However, by the mid-1970s, research on person-centered counseling essentially ended after the deaths of Rogers and Traux (Quinn, 2013). With the notable exception of emotionally focused couples therapy (Johnson, 2004), an empirically supported treatment for distressed couples, contemporary humanistic approaches have not been on the forefront of the evidence-based therapy movement. However, one of the most significant and robust findings in the field of counseling and psychotherapy research is the importance of the counseling relationship: the evidence provides strong and consistent support for many of Roger's ideas about what is helpful in the counseling relationship.

In his 1957 article "The necessary and sufficient conditions of therapeutic change," Carl Rogers set forth a research hypothesis that would define his career and redefine the landscape of psychotherapy for generations to come. In the decades that followed this publication, he pursued a meticulous research agenda that attempted to determine whether his core conditions were a) necessary and/or b) sufficient. In his search for answers, Carl Rogers was the first researcher to record counseling sessions (Brazier, 1996), providing the technological and ethical foundation for *process research*, the study of in-session counseling processes that promote or hinder change. Consistently,

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the vast majority of studies over the past four decades have found that the *client's* perception of the core conditions—more so than the counselor's or a neutral third party's—is correlated with positive outcome (Kirschenbaum & Jourdan, 2005). However, although there is strong support for importance of empathy, positive regard, and congruence, most concede that the core conditions may be neither necessary nor sufficient (Kirschenbaum & Jourdan, 2005). Nonetheless, they are considered "extremely helpful" with virtually all clients.

Common factors research has reintroduced and recontexualized the importance of Rogers' core conditions (Miller, Duncan, & Hubble, 1997; also see Chapter 1). Rather than particular models accounting for change, the common factors movement posits that similarities rather than differences across models are more closely correlated with successful counseling outcomes, with the counseling relationship accounting for 30% of outcome variance (Miller, Duncan, & Hubble, 1997). These findings continue to be replicated in large-scale studies that compare person-centered with cognitive-behavioral and psychodynamic counseling (Stiles, Barkham, Mellor-Clark, & Connell, 2008). Thus, although there has been a revival of Rogers's work, it is likely that the person-centered model will be practiced in combination with other humanistic, experiential, and/or existential approaches (Kirschenbaum & Jourdan, 2005).

Furthermore, there is a significant stream of research that supports experiential counselors' claims that emotional expression promotes well-being (Stanton & Low, 2012). In particular, writing to express emotions has been found to transform meaning and increase positive emotion related to the event (Langens, & Schüler, 2007). Of particular interest, constructive expression of emotion characterizes more satisfying intimate relationships (Yoshida, 2011). Additionally, young families with a positive attitude toward emotional expression also reported a greater sense of social support, suggesting that such an attitude may strengthen relationships on multiple levels (Castle, Slade, Barranco-Wadlow, & Rogers, 2008). In sum, although the specific interventions and overall outcome have not received significant research support, the principles and practices behind the humanistic approach to counseling relationships and to facilitating emotional expression have strong, consistent support.

Person-Centered Case Study

May, a 24-year-old, second-generation Taiwanese American, reports having panic attacks during her first year of veterinary school. She states, "Out of the blue, I just feel like the world is collapsing in on me; my heart races and I can hardly speak." She lives in a dorm on campus, her parents and younger brother living three hours away. She has always excelled academically, having enjoyed subjects such as art, history, and literature more than science and math. Her parents insisted that she choose a realistic and lucrative career, such as medicine, and they compromised on veterinary school because May loves animals. She says that she is happy with her choice to pursue veterinary medicine. Although highly acculturated in many ways, May is low-key and cautious when expressing her emotions or discussing issues that may be shameful to her or her family. She always conducts herself with poise and grace. She has not told her parents that she is seeking counseling at the university health center.

Case Conceptualization: Person-Centered

This case conceptualization was developed by selecting key concepts from the "Viewing: Case Conceptualization" section of this chapter. You can use any of the concepts in that section to develop a case conceptualization for this or other cases.

Stages of the Change Process

AF (adult female) is in the second stage of the change process and is beginning to see that there are problems, which are still seen as external to the self.

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Perception of Problems

At this point, AF perceives the problem to be coming from the outside, almost out of nowhere. She suspects some of the stresses of graduate school "might" be contributing but is not convinced.

Agency and Responsibility

AF does not frequently blame others, nor does she experience a sense of agency in her life. Regarding major life decisions, she still believes that she "has no choice" but to listen to her parents; there is no clear awareness that she can consciously and freely choose to adhere to traditional Taiwanese cultural values that respect the wisdom of elders. In terms of daily living, she is responsible in her approach to school and managing her affairs.

Recognition and Expression of Feelings

AF is able to recognize some of her emotions but does so in a removed and nonexpressive manner that is common in Taiwanese culture, especially when discussing intimate or shameful topics. Even in session when discussing her panic attacks, AF tries to make it appear as if "everything under control." She describes her emotions almost as if they were happening to someone else or happened a long time ago, even positive emotions. Her expression of emotion is fairly typical of Taiwanese/Chinese culture; even so, this tendency may be playing a role in trying to manage her stress in graduate school.

Here-and-Now Experiencing

AF struggles to identify her present moment thoughts and emotions in session. However, with some assistance and facilitation, she is able to recognize her emotions.

Personal Constructs and Facades

AF has developed a personal construct that entails being highly intelligent, as evidenced by her academic success, and always in control of her emotions; there is a general pursuit of perfection. The pressures of graduate school may be challenging this facade and social/family role and thereby contributing to her panic episodes.

Complexity and Contradictions

As is typical for someone of her age, AF has not embraced many of her inner contradictions and life's complexities. The new challenges of graduate school may be raising some of these issues for her, such as encountering failure and fear of the future. She has also abandoned her artistic and literary pursuits to focus on her chosen career, which may be creating anxiety by denying an essential and key part of her true self.

Shoulds

AF has many unexamined "shoulds" that organize her life, shoulds that can be traced not only to messages from her parents, but also from immigrant, upper-middle-class Taiwanese, as well as Chinese American, culture: on all fronts, she has pressure to perform at the top of her class and to be successful in all areas of her life. In addition, she feels contradiction in her family and cultural values that emphasize loyalty and duty to parents, as compared with American values of independence and freedom.

Acceptance of Others

In general, AF is more accepting of others than herself. However, she still perceives others largely in terms of their roles rather than authentic selves.

Trust of Self

AF is vaguely aware of her authentic self, primarily due to her conflicts in career. Typically, she experiences herself and others as static entities, and her description of herself is fixed: "I have always been X." At this time, it is hard for her to make sense of parts of herself that do not fit her image of herself.

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Treatment Plan: Person-Centered

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration:* Maintain a more low-key emotional tone and careful approach to potentially shameful topics.
   Relationship building approach:
   a. Use **unconditional positive regard, accurate empathy, and genuineness** to establish the necessary conditions for change.

2. Assess *individual, systemic, and broader cultural dynamics. Diversity consideration:* Carefully adapt assessment for Taiwanese American norms for **expression of emotion** and **self-constructs**, considering overall high level of acculturation.
   Assessment strategies:
   a. Assess for ability to identify, express, and experience **emotions in present moment**.
   b. Assess for ability to experience self as an **unfolding process, accept proactive responsibility for problems, embrace complexity and contradictions, and experience flow**.

Initial Phase Client Goal

1. *Decrease* **shoulds and oughts** to reduce panic episodes.
   Interventions:
   a. Help client identify, own, and accept emotions underlying panic; instruct client to do so on a daily basis with a journal.
   b. Help client develop a proactive and competent sense of self in relation to complexity and challenge that are part of beginning graduate school.

Working Phase of Treatment

Working Phase Counseling Tasks

1. *Monitor quality of the working alliance. Diversity consideration:* Continually assess whether client feels safe and accepted in counseling relationship, looking for subtle and nonverbal signs of disconnection or shame.
   Assessment Intervention:
   a. Assess for client's ability to express self genuinely and constructively disagree with counselor; Session Rating Scale.

Working Phase Client Goals

1. *Increase* ability to recognize and constructively **express full range of emotions** in culturally appropriate ways to reduce panic.
   Interventions:
   a. **Empathetically reflect** unacknowledged feelings that are difficult for the client to express; address cultural and family rules related to emotional expression.
   b. Assist client in **experiencing emotions** in the present moment using immediacy in session.

2. *Increase* ability to **recognize authentic self** without facades to reduce tendency for high-achieving perfectionism.
   Interventions:
   a. **Process questions** that address less desirable aspects of self to enable client to clarify inner experience of self.
   b. **Immediacy** to help client experience self in relationship to counselor.

(*continued*)

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3. *Increase* ability to view self as **responsible** for her life situation and active agent in making changes to reduce the helplessness associated with her "out-of-the-blue" panic episodes.
   Interventions:
   a. **Confront contradictions** related to perfectionism and powerlessness as they relate to both family and school contexts.
   b. **Immediacy** to help client experience **sense of agency** in counseling relationship and present experiences.

Closing Phase of Treatment

Closing Phase Counseling Tasks

1. *Develop aftercare plan and maintain gains. Diversity consideration:* Help client identify potential sources of support in Taiwanese/Chinese and/or university/professional communities.
   Intervention:
   a. **Process questions** to help client identify how best to manage potential future challenges; terminate only after client has developed ability to reflect on self without assistance.

Closing Phase Client Goals

1. *Increase* ability to experience **self as an unfolding, evolving, and complex process** without holding on to **personal constructs** and a need for perfection to reduce potential for relapse in panic symptoms.
   Interventions:
   a. **Unconditional positive regard** to enable client to also accept all elements of self.
   b. **Process questions** with immediacy to facilitate experience of self in the here and now.
2. *Increase* ability to **authentically communicate** self with families while simultaneously respecting and *enabling* the other to also be fully themselves to reduce potential for relapse in panic or perfectionism.
   Interventions:
   a. Relate to client using **genuineness** and **authenticity** to create context in which it is safe for client to do the same.
   b. **Immediacy** of how client is experienced by counselor in session to enhance ability to effectively relate to others, especially family, as an authentic self.

Questions for Personal Reflection and Class Discussion

1. What are your thoughts about the core conditions being sufficient for change?
   - For which type of clients might this be true?
   - For which type of clients might it not be true?
2. Describe a situation when another person's expression of empathy made a difference in your life. How did the empathy affect you?
3. What do you think of Roger's seven-stage model of change model?
   - What strengths does it have?
   - What limitations?
   - How might it work in cross-cultural counseling situations?
4. In your experience, what differences have you noticed in emotional expression based on a person's:
   - Age?
   - Ethnicity or race?
   - Gender?
   - Sexual orientation?
   - Immigration status?

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5. What strengths does this approach have for working with diverse clients? What limitations?
6. How do you tend to identify the emotional states of others in everyday interactions? What helps the most with this? What are hindrances to this?

Online Resources

Associations and Training Institutes

Association for the Development of the Person-Centered Approach
www.adpca.org

Association for Humanistic Psychology
www.ahpweb.org

American Psychological Association, Division 32: Humanistic Psychology
www.apa.org/divisions/div32

Carl Rogers Website
www.carlrogers.info

Natalie Rogers: Expressive Arts Therapy
www.nrogers.com

World Association for Person-Centered and Experiential Psychotherapy and Counseling
www.pce-world.org

Journals

Journal of Humanistic Psychology
www.ahpweb.org/pub/journal/menu.html

Journal of the World Association for Person-Centered and Experiential Psychotherapy and Counseling
www.pce-world.org/pcep-journal.html

Person-Centered Journal
www.adpca.org/Journal/journalindex.htm

Videos

See the Theory in Action Videos at Cengagebrain.com

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*Asterisk indicates recommended introductory readings.

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CHAPTER

7

Existential Counseling and Psychotherapy

Those who have a "why" to live, can bear with almost any "how."

—Viktor Frankl

Lay of the Land

Existential counseling is grounded in existential philosophy, which addresses questions related to "existence": What is the purpose and meaning of life? Why do we suffer? What is death? Having much in common, there are several distinct strands of existential counseling (Cooper, 2003):

- *Daseinanalysis:* Daseinanalysis (pronounced "da-zine-analysis") employs a more analytic approach to help clients open up to their world and to explore how their way-of-being in the world contributes to their suffering.
- *Logotherapy:* Singular in the existential approaches, logotherapy is based on the belief that life is inherently meaningful.
- *American existential-humanistic approach:* In contrast to Daseinanalysis, which emphasizes the in-the-world nature of being human, the American existential-humanistic approach focuses on the individual's need to be true to his or her own subjective experience, having a more inward focus.
- *British School of Existential Analysis:* Representing a diverse group of practitioners, the more recently developed British School of Existential Analysis includes practices that explore four dimensions of existence, including physical, social, personal, and spiritual.

Because these existential approaches share most of their basic premises and techniques, they will be presented together in this chapter.

In a Nutshell: The Least You Need to Know

Existential counseling and psychotherapy is not for the faint of heart or those who prefer simple, black-and-white life answers. As the name suggests, existential counseling and psychotherapy specifically focuses on helping people to deal with *existential* issues, such as finding life meaning, dealing with crises in identity, confronting our ultimate aloneness, and managing the "big picture" anxieties: What should I do with my life? What have I done with my life? Why on earth didn't I do that with my life? Is there

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really a God/god/Goddess or someone—besides me—who is responsible for all of this? In short, existential counseling "involves assisting people to come to terms with the dilemmas of living" (Van Deurzen, 2002, p. xiiv).

Existential counselors contend that most of the issues for which people come to counseling have an existential root. By addressing these as well as the symptoms, the presenting problem as well as deeper life issues of meaning and significance are also addressed, resulting in longer-lasting effects of counseling. The existential approach is more of a philosophical stance than a concrete set of techniques for how to conduct a session. This philosophy emphasizes that humans are free and responsible for their choices and actions. Through the existential counseling process, clients learn to consciously define themselves and their life rather than feel the victim of circumstance. Rather than "cure" mental illness or psychological conditions, existential counseling helps people to live more authentic lives that have meaning and purpose.

The Juice: Significant Contributions to the Field

If you remember one thing from this chapter, it should be ...

I-Thou Relationship

> If *Thou* is said, the *I* of the combination *I-Thou* is said along with it.
> If *It* is said, the *I* of the combination *I-It* is said along with it.
> The primary word *I-Thou* can only be spoken with the whole being.
> The primary word *I-It* can never be spoken with the whole being. (Buber, 1958, p. 1)

When studying to become a counselor—if you are lucky—a handful of readings will strike like dynamite and shatter the foundation of what you think you know. I have come to believe this is due as much to reader readiness and timing as it is to the wisdom of the text. Martin Buber's (1958) *I and Thou* was one of these cataclysmic readings for me. When I first read it, I carried it everywhere and read it whenever I had a free moment, whether at the gym, filling my gas tank, eating a snack, or waiting for a class. Much to the annoyance of everyone in my life, I was so excited I couldn't stop talking about it. Therefore, years later as a new professor, I wanted my students to read it and have the same rock-your-life experience. Instead, they hated it. They revolted, saying it was indecipherable poetry that had no bearing on counseling or the modern world, for that matter. I am sure they sold their books back to the bookstore before the end of the semester. Taking a hint, I never assigned it again. However, being crafty and persistent, I developed a related experiential assignment that students have come to love using the same I-Thou principles. But, before I share it with you, we need to define some terms.

Buber viewed existence as a *relational encounter*. Humans can be in relation in one of two ways: *I-Thou* (*Ich-Du* in the original German) or *I-It* (*Ich-Es* in German). In the I-Thou encounter, a person experiences the other as a fully independent subject (person or agent); each is fully authentic and receptive to the other's authenticity in this moment. This encounter is not characterized by communication of information but rather is a profound moment of witnessing and beholding the other, generally without words, as it is a state of being. Common experiences of I-Thou encounters include two lovers, an observer and a nature scene, a mother and an infant, or a religious seeker and God. In contrast, during an I-It encounter, the person engages the other as an object, more of a mental representation or class of person than an independent, authentic entity. In an I-It relationship, a person essentially relates to his or her conceptualization of the other rather than the actual other. Most of human life is spent in I-It encounters, whether ordering lunch at restaurant, diagnosing a client, or planning a wedding.

Buber maintained that human existence oscillates between these two modes of being, with I-Thou moments increasingly rare and devalued in modern cultures that emphasize efficiency, productivity, and social class. Furthermore, Buber emphasized that humans experience their humanity, purpose, and deepest joy only in the I-Thou moments. Humanistic and existential counselors and psychotherapists use Buber's distinction of I-Thou to conceptualize the counselor–client relationship as an I-Thou encounter in which each encounters the other as a separate, authentic self.

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After my students told me that Buber's writings were too esoteric, I asked them to instead engage in mini "experiments" with I-Thou encounters. Over the course of the week, I asked them to choose three people—a stranger, an acquaintance, and an intimate other—and to strive to have an I-Thou and I-It encounter with each (for the stranger, they may need to do it with two different people). Granted this is a bit staged, but surprisingly almost all students returned the next week reporting that it was easiest to have an I-Thou encounter with a stranger, such as a store clerk or a person on the street. Friends and family members often didn't pick up on the students' attempts or were guarded because they feared that a "heavy topic" was being raised. In contrast, a stranger, although often caught off guard and not expecting a gesture of genuineness, tended to be more willing to be seen and more receptive. Perhaps this explains why counseling and psychotherapy have developed a strong tradition of privacy and confidentiality.

Try It Yourself

Find a partner to have two conversations. In the first, discuss how the two of you might work together to help each other learn the ideas in this chapter. That would be an I-It discussion. Then, start a second conversation about how the other is experiencing the material in this chapter: ask about how the person is making his/her unique meanings, the impact it is having on the person, etc.; simply try to fully understand his/her experience.

Rumor Has It: The People and Their Stories

Viktor Frankl

Born in Vienna to a Jewish family, Frankl, his wife, and his parents were sent to concentration camps, including Auschwitz and Türkeim. He was the only person to survive the camps besides a sister who escaped to Australia. As a trained psychiatrist, he was asked to assist newcomers in coping with shock and grief, and eventually he set up a suicide watch program in the camps. He worked to help fellow prisoners overcome despondency and hopelessness. His extraordinary experiences in concentration camps led him to develop *logotherapy*, therapy through meaning. He believed that even in the most dehumanizing, painful, and absurd circumstances, humans can find purpose, meaning, and the will to live. It was this sense of meaning that made the difference between life and death for many in the camps, determining who had the will to survive. After the war, he wrote *Trotzdem Ja zu Leben Sagen* (Saying Yes to Life Despite It All), which was translated into English as *Man's Search for Meaning* (Frankl, 1963). His later works included *The Doctor and the Soul* (1965) and *The Unheard Cry for Meaning* (1978).

Martin Buber

An Austrian-born Jewish philosopher, Martin Buber (1958) is most famous for his 1923 work *I and Thou*. He held a position at the University of Frankfurt am Main when Hitler came to power in 1938 and fled to Israel and settled in Jerusalem, where he continued his work on religious existential philosophy.

Rollo May

Born in Ohio, Rollo May (1961, 1969, 1973, 1981, 1983) had a difficult childhood; his parents divorced, and his sister was treated for schizophrenia. May was a key figure for bringing existentialism to the United States and applying the ideas in psychotherapy. His work emphasized that resisting anxiety takes courage and that our choices determine and shape the type of person we become. May founded the Saybrook Graduate School in San Francisco.

Irvin Yalom

Born in Washington, D.C., to a poor Jewish family, Irvin Yalom pursued a career in psychiatry, serving on the faculty at Stanford University. His existential approach (Yalom, 1980) identifies "four givens" of existence: death, freedom, existential isolation, and meaninglessness. In addition, his *Theory and Practice of Group Psychotherapy*

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(Yalom, 1970) is a highly influential text used by group therapy practitioners from virtually all theoretical approaches.

Big Picture: Overview of Counseling Process

The purpose of existential counseling is to help clients take responsibility for the circumstances in their lives and to make conscious choices that enable them to live more meaningful, authentic lives. Yalom (1980) further clarifies that existential counseling helps clients address the following four areas: (a) death and anxiety, (b) freedom and responsibility, (c) isolation and relationship, and (d) meaninglessness. Through an I-Thou, authentic connection (Buber, 1958) with their counselor, clients are encouraged to identify and confront the existential anxieties that underlie the problems and concerns they bring to counseling. More so than other humanistic-phenomenological approaches, existential counseling emphasizes insight in a style reminiscent of psychodynamic counseling theories (Yalom, 1980). Although existential counselors do not define progressive stages of counseling, in general there are three phases, which clients may move between many times while in counseling:

- *Phase 1:* Identify how the presenting problems related to the client's existential assumptions and beliefs.
- *Phase 2:* Clients examine and redefine attitudes regarding death, freedom, anxiety, responsibility, choice, meaning, meaninglessness, isolation, and so on.
- *Phase 3:* Clients take specific action to lead a more fulfilling, meaningful, and self-actualized life.

Making Connection: Counseling Relationship

I-Thou Relationship Between Counselor and Client

Although much of the counseling relationship will involve I-It encounters (Buber, 1958; see the "I and Thou Relationship" section under "Juice"), the counseling relationship involves cultivating the type of presence that characterizes I-Thou connections. In counseling, the I-Thou encounter generally takes the form of the counselor bearing witness to the client's humanity and struggle with the human condition. These are often silent moments in which the client feels "seen" and "heard" at a profound level. In taking an I-Thou stance, the counselor presupposes that clients have the ability to cope with life's difficult realities without overreliance on the counselor for encouragement and support. The counselor demonstrates empathy and concern but also, above all, trust in the client's ability to engage life in increasingly authentic ways.

Here-and-Now Presence

Existential counselors use their quality of presence (Bugental 1987; Krug, 2009) to help clients increase self-awareness, develop insight, take responsibility, and make choices. They believe that focusing clients on present moment, here-and-now experiences is the most effective way to help people change how they relate to themselves and others. Existential counselors focus on both *intrapersonal* (e.g., preverbal, kinesthetic, and tacit dimensions of experience) and *interpersonal* (e.g., safe and intimate relationships) forms of presence. Counselors encourage clients to identify what they are feeling and experiencing in the present moment and to examine their fears, anxieties, and yearnings that may underlie these feelings.

Promoting Responsibility and Independence

Existential counselors relate to clients in such a way as to maximize their sense of responsibility and independence, often by way of having them confront their ultimate *existential isolation* and separateness from others, including the counselor (Yalom, 1980). Although existential counselors may empathize with clients, they are careful to never imply that "I'm right there with you" because, ultimately, no one is. Existential counselors are more willing to allow their clients to experience the fullness and reality of this isolation—not to be cruel and uncaring—so that clients can live more authentically and will be motivated to make better choices. Thus, existential counselors avoid

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being overly reassuring, overly supportive, or overly helpful, so that clients feel a stronger pull to take responsibility for their own lives.

The Viewing: Case Conceptualization

Existential counselors do not use formal methods for case conceptualization and instead explore the following universal and existential concerns in clients' lives:

- Meaning, meaninglessness, and purpose
- Freedom and responsibility
- Existential anxiety and guilt
- Death anxiety
- Existential angst
- Purpose of neuroses

Meaning, Meaninglessness, and Life Purpose

Most existentialists believe life is inherently *meaningless* (Yalom, 1980). They do not believe that there is a grand design to life or that we are each here with a specific purpose, thus differing with humanistic counselors who believe that all people share the general life purpose of self-actualization (Rogers, 1961). *Christian existentialists*, who draw primarily on the work of Kierkegaard (an existential philosopher who was also a devout Christian), believe that each person has free will and must *choose* to take a "leap of faith" in the face of life's apparent meaninglessness (Bretherton, 2006). Nonetheless, existentialists recognize that without meaning and purpose, a person is adrift in life. Thus, they believe that each person must consciously choose sources of meaning and purpose: "The meaning of life differs from man to man, from day to day and from hour to hour. What matters, therefore, is not the meaning of life in general but rather the specific meaning of a person's life at a given moment" (Frankl, 1963, p. 113). Frankl maintained that this *will to meaning* is the primary drive in a person's life.

Existential therapists focus their work on helping clients find life *Meaning*—that's "meaning" with a capital "M." They help people step back and look at the big picture of their life and ask difficult questions, such as the following: Is this *really* what I want for my life? Am I living a life that has meaning for me? Is this the life I dreamed of? If not, why not, and how do I get where I want to go? If you are new to the practice of counseling, these may seem like obvious questions that all counselors address. However, most clients come in crisis—such as a pending divorce, lost job, or psychotic break—or because of significant problems getting through the day—such as too depressed to get up, go to work, and have a conversation with the spouse and child over dinner. Much of the work in counseling addresses struggles in daily living—micro-level problems—and it can be hard to shift focus to the macro-level, existential issues.

Recent research on happiness by positive psychologists as well as the mental health recovery movement emphasize the importance of living a life with meaning and significance. In researching people who seem happier than the average, these people report that they feel their life has meaning and greater purpose (Seligman, 2002). Similarly, in recovery-oriented work with persons diagnosed with severe and persistent mental illness, the primary goal is to restore a sense of meaning and purpose more so than to reduce symptom frequency; once a person has meaning and purpose, he or she is more likely to move toward recovery (Davidson, Tondora, O'Connell, Lawless, & Rowe, 2009).

Working with people on life meaning can involve several steps and stages. First, counselors need to help clients identify sources of meaning and purpose. For some, this is easy; they can quickly articulate these even if they are taking little action in the present. These clients may have abandoned life dreams and goals when they settled for a more practical career or started a family earlier than planned. For others, identifying significant and sincere sources of meaning is an extremely difficult task. In some cases, they never clearly articulated any type of purpose, dream, or other meaning in childhood and adolescence, perhaps because they or their parents were more focused on following what was socially expected rather than relying on an internally generated life direction. For these clients, counselors need to move more slowly and creatively to help them discover what inspires and moves them, which may be a new life experience.

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Once potential sources of life meaning are identified, clarified, and owned by the client, the next step is to determine how best to translate these into real-world action. In most cases, wholeheartedly pursuing these dreams would be destructive on many levels: quitting a high-paying job that supports a family of four to pursue life as a painter or sailing the globe may create more distress than joy. Thus, in many cases, the task becomes identifying ways to create that meaning within the fabric of the current life, perhaps through hobbies, a shift in career, a new relationship, or daily practices. In other cases, creating a life with purpose means reengaging in one's existing relationships, career, and pastimes from a new perspective and openness that is meaningful. The classic example of this is the father and husband who is overinvested in his work life and underinvested in his family; a shift of perspective and scheduling priorities often creates a dramatic shift in a sense of connection and life purpose. Similarly, in the case study at the end of this chapter, the counselor helps Ben, a 34-year-old gay man struggling with alcohol issues, find more effective and substantial sources of meaning in his life, which had become narrowly defined by partying and recovering from partying on the weekends.

Try It Yourself

Either on paper or in dialogue with a partner, identify the most significant forms of meaning in your life. How do they shape your decisions, behaviors, values, and relationships?

Freedom and Responsibility

Frankl's (1963) advice for living responsibly is as follows: "Live life as if you were living already for the second time and as if you had acted the first time as wrongly as you are about to act now!" (p. 114). Existentialists maintain that even though humans have certain limits to their freedom (e.g., they cannot control externals), they always have the freedom to choose how they *respond* to a situation. Frankl's role model for how one can choose to respond with dignity and integrity, even in the most horrific life experiences—he survived four concentration camps—quickly quells quibbling on the subject. Ultimately, a person's greatest freedom is how he or she chooses to interpret (make meaning) and respond to life circumstances. Yalom (1980) further explains that humans aren't just free; they are "doomed" to freedom in that freedom implies responsibility. The freedom to make meaning and respond also implies responsibility for how one shapes and directs one's life. A person is responsible not only for actions taken but also for actions *not* taken: one's failure to act. May (2009) further explains, "Freedom does not come automatically; it is achieved. And it is not gained at a single bound; it must be achieved each day.... The basic step in achieving inward freedom is 'choosing one's self'" (p. 125).

When initially developing a case conceptualization, counselors listen for how clients describe their life circumstances: Are they victims of life, or are they the creator of their realities? When life gets off course, whom do they blame, and to whom do they turn to get back on course? Do they feel like they have control and freedom over how they respond, or do others "make them" respond badly? Do they feel that they have freedom without responsibility? It doesn't take long to get a sense of how fully a person has embraced his or her existential sense of freedom and the associated responsibility.

Capacity for Self-Awareness and Consciousness

May (2009) identifies the capacity for self-awareness as the hallmark quality of being human. Relatively early in life, humans are able to distinguish between "I" and the rest of the world. This awareness of self enables people to be aware of others and their desires, time, and its implications for the self; to examine history and its implications; and even to reflect on the self and awareness itself. In working with clients, counselors assess the extent to which a client is self-aware of thoughts, feelings, choices, desires, and actions, and how these affect others. Promoting awareness of all aspects of being becomes a central goal in existential counseling.

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Death Anxiety

Existentialists maintain that a person's fear of death—an undeniable and unalterable aspect of human existence—plays a major role in their psychopathology (Yalom, 1980). Virtually all humans are in denial about death to one extent or another and erect defenses to avoid this reality. The type of defense against death shapes a person's character structure, such as attempting to delay it by living healthfully, focusing on religious practices designed to transcend death, worrying about safety and health, living as though one is immune, or keeping oneself so busy that there is no time to think about it. Generally, one of these or similar strategies work to keep the death anxiety at bay. However, in cases of psychopathology, the person has not found an effective approach for managing this fear. When assessing clients, existential counselors consider the following questions:

- How does the client's presenting symptoms serve to manage his or her existential death anxiety?
- What are the beliefs—and sources of the beliefs—that fuel the client's particular fears of death?
- Is the client able to speak about death, fear of death, or his or her view of death?

Although existential counselors don't necessarily rush to the topic in the early phases, they use clients' description of their problems and how they handle them to identify how the fear of death shapes the presenting problem. However, they encourage clients to muster the courage to embrace the fact that they—and those they love—will die. The more deeply one acknowledges this fact, the more likely the person is to take responsibility for life, make better choices, and create a meaningful life. Living without awareness of life limits is more likely to lead to irresponsible and more regrettable life decisions.

Existential Angst

Existentialists posit that all people experience *existential angst* or *existential anxiety*, which should never be confused with garden-variety neurotic anxiety you read about in your diagnosis class (May, 2009). The existential versions are part of the package of human existence and refer to anxieties that often underlie and fuel other concerns and issues: the stress that comes from engaging freedom, choice, isolation, meaninglessness, death, and so on. The more aware one is of these existential realities—particularly the fact that each of us is free to make choices and is therefore responsible for who we become, how we affect others, and the quality of life we live—the *more* one experiences existential angst. When experiencing moments of existential angst, a person experiences intense awareness of how each decision irrevocably shapes one's life—and yet one cannot avoid choice and the heavy burden of freedom. In general, existential anxiety is not considered pathological—like the anxieties listed in the *Diagnostic and Statistical Manual of Mental Disorders*—but are considered *normal anxieties* (Reeves, 1977) and an essential part of conscious living. In fact, for most clients, existential angst is a sign that a person is becoming more aware of choices, freedoms, and responsibilities that are inherent to the human condition; by facing these existential anxieties, a person develops a stronger sense of being and affirms the self in the world.

Purpose of Neuroses

May (1961) asserts that every person (plant and animal for that matter) is "centered in herself [or himself] and an attack on this center is an attack on her or his existence itself" (p. 74). Therefore, he views presenting problems, anxieties, and neuroses as serving the purpose of preserving a person's centeredness, sense of self, and, ultimately, his or her own existence. For example, fears and neurotic anxieties are a person's response to avoid a perceived threat, anger and aggression are an attempt to protect the self by attacking a threat, and depression is an attempt to retreat from a threat. By viewing symptoms as a strategy for preserving the self against the perceived threat of harm or annihilation, existential counselors can quickly identify where pivotal choices need to be

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made and responsibility needs to be taken. For example, in the case study at the end of this chapter, the counselor helps Ben see how he uses alcohol to create an artificial and precarious sense of meaning and avoid directly confronting more critical existential realities, such as giving up early on two of his greatest life dreams.

Targeting Change: Goal Setting

The goals in existential counseling focus on encouraging clients to live more authentic lives by changing how they relate to broader existential anxieties and generate life meaning. The approach focuses on long-term changes at an existential level rather than on the everyday symptoms with which the client may have presented. For example, if a woman reports feeling depressed after losing a relationship, the goals of treatment would target changing how she experiences being alone and/or how being in a romantic relationship affects her identity, rather than focusing simply on reducing her depressed mood. Existential counselors maintain that it is the underlying meaning of the problem that needs to change, more so than the person's life circumstances. Thus, early and middle phase goals are smaller steps along the way to achieving broader life goals.

The goals often address issues such as the following:

- Increasing a person's sense of meaning and purpose
- Reducing existential anxiety and/or fear of being alone
- Creating greater acceptance of death, loss, or change
- Developing a sense of identity that is less dependent on externals, such as a job, financial status, relationship status, and so on

Examples of working or closing phase client goals include the following:

- Increase ability to generate a sense of meaning and purpose in his or her life that is less dependent on the opinion of others
- Increase ability to manage existential anxieties about being single
- Increase acceptance of the process of aging

The Doing: Interventions

Similar to person-centered counselors, existential counselors do not use a standard set of interventions but instead rely more heavily on the person of the counselor to promote change. That said, there are several areas of particular focus in which they use their presence to help clients become more authentic and self-aware. These are discussed next.

Search for Meaning and Promoting Choice

"We must never forget that we may also find meaning in life even when confronted with a hopeless situation.... When we are no longer able to change a situation—just think of an incurable disease such as inoperable cancer—we are challenged to change ourselves" (Frankl, 1963, p. 116). Existential counselors help clients find meaning and purpose when facing life difficulties by redirecting their energies to changing how they *choose* to view and respond, rather than lamenting an unchangeable situation. Counselors may do this by focusing on the spiritual dimension, existential elements, or any available source of reinterpretation. For example, when a client is diagnosed with terminal cancer, an existential counselor may shift the client's attention to *living* the last months with dignity.

Common strategies for choosing meanings that focus on changing oneself when the situation is unchangeable include the following:

- *Spiritual perspective:* Using religious and spiritual beliefs to view and recontextualize the situation so that there is more hope and meaning (e.g., there is life after death)
- *Existential philosophical perspective:* Offering existential philosophical views of death, isolation, responsibility, and freedom to promote greater agency (e.g., I am responsible for how I approach and free to choose how that will be)

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- *Relational perspective:* Generating purpose and meaning by examining how one's choice affects significant others (e.g., I will live these last three months with courage because my children and husband need me to)
- *Identity preservation:* Deciding to take action that is congruent with one's view of self (e.g., I have lived my life with dignity and courage, and I shall approach death in the same way)

Acknowledging Existential Isolation

Although isolation comes in many forms, *existential isolation* refers to "an unbridgeable gulf between oneself and any other being" (Yalom, 1980, p. 355). Existentialists maintain that acknowledging this isolation is critical for creating life meaning and taking responsibility for one's life. "Deep loneliness is inherent in the act of self-creation" (p. 357), and thus a person isn't motivated to take active responsibility for who he or she is and becomes until he or she accepts the gravity of separateness. Early in the counseling process, counselors find appropriate moments to point out how ignoring existential isolation is contributing to problems in a client's life. Common examples include: not consciously acknowledging one's own desires because a loved one (e.g., spouse, parent, or friend) would disapprove, making poor decisions to avoid feeling lonely, and staying in abusive relationships.

Defining and Affirming Self: Achieving Freedom

May (1961) discourages counselors from focusing on the *whys* and *hows* of the presenting problem and instead encourages them to focus on the intricacies of the "living, existing person here in the room with me" (p. 74). Viewing symptoms as perceived threats to the self, the counselor's attention is directed to gaining an understanding of the client's *subjective* awareness of self and the perceived threats to the self. The counselor encourages *self-affirmation* in those contexts in which the client feels threatened. For example, if a client is experiencing "stress" at work, the counselor would help the client identify the ways in which he or she perceives threats to the self, sort out existential from garden-variety neurotic anxieties, and encourage him or her to make decisions to take responsibility for preserving his or her sense of self and centeredness in the work context.

Courage and Encouragement

Much of what an existential counselor does is promote the *courage* required to be fully aware of one's own humanity (Frankl, 1963; May, 2009). Facing the reality of death, loneliness, and responsibility for one's life is no picnic. It's almost human nature to run from such truths. Yet being human demands that one face these realities at some point in life. To do so, we all need encouragement; that is exactly what the existential counselor offers: the encouragement to go to the places that scare you most. Ultimately, that's all the counselor can offer because simple, easy answers aren't available for existential questions such as why we are here, who I am, and how I should live my life. Much of the encouragement is communicated nonverbally by the counselor demonstrating courage to substantively explore these issues. In the case study at the end of this chapter, the counselor uses encouragement throughout treatment to help Ben examine the unpleasant effects alcohol is having on his life and to have him revisit life dreams he had long given up on.

Love and Belongingness

Aware of the ultimate reality of isolation, existential counselors are all the more aware of the importance of human connection. May (2009; Reeves, 1977) identifies love as an important element of being human. Requiring a fair degree of self-actualization, May's specific definition of love is to delight in the presence of another, affirming the other's value and development as much as one's own. As experienced by the self-actualized person, love involves conscious will, freedom, self-awareness, empathy, choice, and courage. He warns that "when 'love' is engaged in for the purpose of vanquishing loneliness, it accomplishes its purpose only at the price of increased emptiness for both persons"

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(May, 2009, p. 183). Such love is simply a form of dependence. Instead, May claims that "you can only love in proportion to your capacity for independence" (p. 183). In session, existential counselors use this definition of love to help clients develop loving relationships that reflect a conscious choice to delight in being with the other while minimizing demands and dependency.

Paradoxical Intention

Frankl (1963) made a distinction between existential (normal) fears and neurotic fears and used different techniques for both: "A realistic fear, like the fear of death, cannot be tranquilized away by its psychodynamic interpretation; on the other hand, a neurotic fear, such as agoraphobia, cannot be cured by philosophical understanding" (p. 124). For neurotic and phobic fears, he recommends *paradoxical intention*, in which the client is invited to imagine and/or intend to have happen that which is feared. Frankl emphasized that this technique must be used in a playful, humorous spirit that promotes self-detachment. For example, if a person tends to panic in public places, the client would be asked to put together a detailed plan for going to a public place and doubling the intensity of the panic attack—the client is explicitly asked to make it bigger, more dramatic, and more outrageous than before. This assignment has the paradoxical effect of enabling the client to realize control over what seemed uncontrollable. This technique is also used in cognitive-behavioral and systemic family approaches.

Putting It All Together: Existential Case Conceptualization and Treatment Plan Templates

Theory-Specific Case Conceptualization: Existential

Use the prompts below to develop a theory-specific case conceptualization; the case study at the end of the chapter provides an example.

- *Meaning, Meaningless, and Life Purpose:* Describe sources of meaning for client; may involve the following themes:
  - Personal achievement and work
  - Significant other
  - Children
  - Family of origin
  - Social cause/contributing to others
  - Religion/spirituality
- *Freedom and Responsibility:* Describe to what degree and how client experiences a sense of existential freedom and balances this with demonstration of existential responsibility.
- *Capacity for Self-Awareness:* Describe client's capacity for deeper awareness and self-reflection.
- *Death Anxiety:* Even if client does not describe a conscious fear of death, describe how life choices and decisions reflect a particular expression of death anxiety (e.g., cautious, rule following, rule avoiding, risk taking, etc.).
- *Existential Angst:* Even if client does not verbally describe existential angst, describe how client's behaviors and choices relate to dealing with fundamental isolation, separateness, and meaninglessness.
- *Purpose of Neuroses:* How does the client's presenting problem or symptom serve to buffer the client from existential angst and meaninglessness?

Treatment Plan Template: Existential

Use this treatment plan template for developing a plan for clients with depressive, anxious, or compulsive types of presenting problems. Depending on the specific client, presenting problem, and clinical context, the goals and interventions in this template

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may need to be modified only slightly or significantly; you are encouraged to significantly revise the plan as needed. For the plan to be useful, goals and techniques should be written to target specific beliefs, behaviors, and emotions that the client is experiencing. The more specific, the more useful it will be to you.

Treatment Plan

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration:* [Describe how you will specifically adapt your approach to be sensitive to client diversity when developing the counseling relationship; this may include respecting cultured and gendered norms for emotional expression.]
   Relationship building intervention:
   a. Create opportunities for **I-Thou** encounters and experiencing; promote **independence** and **responsibility**.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Assess freedom and responsibility for gender and cultural expectations for collectivism versus individualism.
   Assessment strategies:
   a. Identify sources of **life meaning**, **purpose**, and sense of **freedom/responsibility**.
   b. Assess for coping related to **death anxiety** and **existential angst** as well as capacity for **self-awareness**.

Initial Phase Client Goals

1. *Decrease* client's attempts to avoid **existential angst** and **responsibility** to reduce [specific crisis symptoms].
   Interventions:
   a. Identify perceived threats to self and affirm self in relation to those threats.
   b. **Encourage** client to fully experience and acknowledge the fears and angst that client has been trying to escape through crisis behaviors.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* [Describe how you monitor the client's ongoing sense of connection with counselor and how you will specifically adapt monitoring and/or relationship based on client age, gender, cultural, sexual orientation, socioeconomic status, etc.]
   Assessment Interventions:
   a. Assess for increasing capacity for ability to readily and comfortably experience **I-Thou** connection in session.

Working Phase Client Goals

1. *Increase* ability to identify significant sources of **purpose** and **life meaning** to reduce [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. **Encourage** client to find sources of meaning that are worth living and struggling for.
   b. Affirm client's **sense of self** in relation to perceived threats as well as perceived life **purpose**.

(*continued*)

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2. *Increase* capacity to take **responsibility** for daily choices and overarching life direction to reduce [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. **Encourage** client to assume **responsibility** for self in situations that cannot be otherwise significantly changed or fixed by the client.
   b. Acknowledge **existential isolation** and the forms of **responsibility** derived from this insight.
3. *Increase* capacity to tolerate **anxiety** and **existential angst** to reduce [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. **Encourage** client to acknowledge and take **responsible** action in relation to existential anxieties related to **death**, **freedom**, **isolation**, and **responsibility**.
   b. Encourage client to find relationships and/or communities in which he or she can feel a sense of **belonging** and **responsibility**.

Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity consideration:* [Describe how you will access resources in the communities of which they are a part to support them after treatment ends.]
   Intervention:
   a. Help client identify ways to continue balancing **freedom** and **responsibility** in the face of existential challenges.

Closing Phase Client Goals

1. *Increase* capacity to **authentically experience and express self** by living a life of **purpose** and **meaning** to reduce potential for relapse in [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. **Encourage** clients to fully embrace life, life purpose, and self by authentic connection and self-expression.
   b. **Paradoxical interventions** to have client experiment with authenticity and facades to decrease tolerance of facades.
2. *Increase* ability to engage in **meaningful relationships and communities** to reduce potential for relapse in [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. **Encourage** client to develop the ability to readily have **I-Thou encounters** with significant others, friends, families, and others in the community.
   b. **Encourage** client to take interpersonal risk to be **authentic self** in relation to others.

Research and the Evidence Base

Although existentialists have documented numerous detailed case studies, little systematic research has been conducted on this approach (Mendelowitz & Schneider, 2008; Yalom, 1980). The most robust findings have been that the qualities of the counseling relationship espoused by humanistic counselors have been found to be one of the most significant common factors that predict positive outcome in all forms of counseling (see Chapter 1).

As you can imagine, as a highly philosophical approach, operationalizing existential concepts into discrete, measurable units is challenging, and this accounts for one reason why there is little rigorous study of this approach (Lantz, 2004). In addition, most

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counselors who are enthusiastic about this approach are typically more interested in philosophical than scientific implications (Mendelowitz & Schneider, 2008). Similar to the person-centered approach, the most significant research foundations for the existential model are found in the common factors literature that has identified an engaged, emotionally supportive counseling relationship as one of the best predictors of counseling outcome (Schneider & Krug, 2010). Nonetheless, some researchers have examined existential counseling in greater depth. For example, Goldner-Vukov, Moore, and Cupina (2007) found that psychoeducation combined with existential group sessions significantly improved outcomes with bipolar clients. In a study that considered physiological affects, van der Pompe, Duivenvoorden, Antoni, and Visser (1997) found that after 13 weeks of existential group counseling, a woman diagnosed with breast cancer had improved immune and endocrine functioning. Similarly, a recent Norwegian study on persons with long-standing depression and with religious or existential concerns found that those receiving existential-based therapy had significant improvement, reduced medication, and more employment compared to those receiving treatment as usual (Stålsett, Tore, Rønnestad, & Monsen, 2012).

Tapestry Weaving: Working with Diverse Populations

Cultural and Ethnic Diversity

From an existential position, one of the main purposes of culture is to help its members cope with existential issues such as birth, death, loss, and meaning (Kesebir, 2011). By identifying "good" and "bad," culture shapes its members' values and beliefs, providing a means for navigating life's inherent existential challenges. Kesebir (2011) further argues that cultures are also organized to reward their members for participating in and contributing to culture by offering the potential to achieve some form of immortality—literally or metaphorically—and thereby escape death, something humans seem so strongly motivated to achieve. The role of the existential counselor in some cases is to challenge such a myth.

For existentialists, culture is a powerful force for helping clients address the existential dilemmas in their lives. However, cultural "realities" or truths are always a secondary truth to the client's own lived experience: in the end, the existentialist counselor challenges clients to relate to and make sense of their own experience. Because of this emphasis on the individual's subjective lived experience, existential counseling—like person-centered counseling—can be adapted to work with diverse clients, and may be particularly helpful to clients struggling to make sense of multiple cultural contexts (e.g., immigrants, religious minorities, sexual minorities, and others). That said, the emphasis on more subtle existential issues may be a poor match for clients who might prefer a more structured and/or practical approach (e.g., the impoverished, men, or immigrants).

Because existential counseling seeks to address issues at the heart of the human condition, such as death, greater meaning, and purpose, it has been used with clients from a diverse range of backgrounds (Hoffman, Yang, Kaklauskas, & Chan, 2009). However, the specific style, form, and timing of discussing existential issues vary greatly across cultures, and thus existentially oriented counselors must thoughtfully adapt the approach accordingly. Of particular interest, the existential approach has unique applications when addressing spiritual issues in counseling, providing counselors with clear conceptual guidelines and techniques for addressing the subtle and often highly emotional issues related to spirituality and religion (Hoffman, 2008). Similar to person-centered counselors, existentialists should be careful to avoid inadvertently forcing existential or humanistic values on clients from communal cultures, such as valuing individualism and direct emotional expression over community-focused values.

Sexual Identity Diversity

Until recent decades, existential counselors have been "oddly" silent on this issue of same-sex attraction and alternative sexualities, perhaps because psychodynamic theorists have

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long been viewed as the experts in this area (Medina, 2008). As existentialists enter the debate, their focus is on the lived experience of being gay, eschewing biological considerations. The focus from an existential position is *how* sexual identity is constructed. Being-in-the-world-homosexuality is less concerned about the "truth" per se, but rather it attends to how this orientation translates into everyday action, decisions, and identity: "To a large degree the given aspect of our sexuality means everything and nothing to us at the same time: everything because when it upsurges it envelops all of the self and is in fact all of the self; and nothing because the way in which we respond to this sexual given is ultimately totally subjective and is only formed by 'being there' and experiencing the other through embodied engagement" (Medina, 2008, p. 139). The emphasis is always on the lived experience of sexuality rather than its political implications (Milton, 2007).

From an existential position, one of the primary concerns with alternative sexual identities is the potential to live from an inauthentic position because a person wants to avoid the negative social consequences (Milton, 2007). Thus, an existential counselor encourages clients to go within to explore their lived experience as it actually was, while separating experience from what they believe others think it should be. The focus becomes on the embodied experience of one's sexuality as well as the interpersonal reality of it (Milton, 2007). A practical application of this principle, Milton (2007) describes working with a man questioning his sexual orientation, and he invited the client to avoid the label for the moment and simply focus on the lived experience of his sexuality and attraction: "Does it need a name yet? Or can we just think about what it is you are experiencing"? (p. 52).

Existential Case Study

Ben, a 34-year-old plumber, says he is coming to counseling because his partner, Adam, said he would leave him if he didn't "deal with the drinking issue." Ben states that he likes to party on the weekends, hanging out at clubs and bars with his partner. He admits that he drinks to get drunk but quickly adds that he never drinks and drives and does not use illegal drugs. His partner, who works as an accountant, finds Ben's behavior "out of control," as he flirts with other men, is quick to anger, and is nonfunctional the next day. Although he rarely misses work because of drinking, he admits that sometimes it affects his performance. The youngest son and a second-generation Polish Jew, Ben also states that he never lived up to his parents' expectations of him in terms of either his career or having a family, although they have been generally supportive of his being gay. Although raised Reform Jew, he says that he does not attend services regularly because it does not fit with his current lifestyle. He also states that his original life goal was to be lawyer but that he partied too much in college and did not get good enough grades to go to law school. He chose plumbing because he is good at it and can make a decent living. He sometimes wonders if he wants to have children but doesn't think it is a good idea for a gay couple to adopt.

Case Conceptualization: Existential

This case conceptualization was developed by selecting key concepts from "The Viewing: Case Conceptualization" section of this chapter. You can use any of the concepts in that section to develop a case conceptualization for this or other cases.

Meaning, Meaninglessness, and Life Purpose

AM's (adult male) alcohol abuse seems to be rooted in his sense of not having fulfilled life dreams to become a lawyer and have a family. The alcohol and partying create a sense of excitement that distracts him from his underlying sense of meaninglessness in his life. It is unclear if, and in what ways, being gay may affect his sense of life purpose and meaning, but he likely needs to explore the existential issues related to being gay and part of a marginalized group. Although he is not currently practicing, his Jewish faith is a resource he can draw on to help him find greater meaning and purpose.

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Freedom and Responsibility

Although AM does not describe himself as victimized by life, he certainly is not taking responsibility for its direction or experiencing a sense of freedom that comes from having a sense of agency in life. In many ways, his alcohol use helps him to avoid responsibility for the important decisions in his life and allows him to maintain minimal levels of satisfaction that keep him from striving for what he really wants.

Capacity for Self-Awareness and Consciousness

Although AM is capable of meaningful self-reflection, he avoids it by partying and overindulging on the weekends.

Death Anxiety

Although AM does not discuss anxiety related to death, such anxiety is inherently related to one's sense of purpose and meaning. By not drinking and driving, he clearly values life and is not taking unnecessary risks.

Existential Angst

AM's alcohol use can also be seen as a tool for managing existential angst, which is likely heightened by being gay and part of a marginalized group. Having not pursued two major goals in life, including not having a family, is likely exacerbating his sense of being alone and without a clear purpose or answer for the question "What is this all for?"

Purpose of Neuroses

Whether consciously intended or not, one of the effects of being intoxicated and hung over every weekend is that it serves to avoid emotionally intimate connection with others. AM will need to work on developing the capacity to engage in I-Thou encounters.

Treatment Plan: Existential

Initial Phase of Treatment

Initial Phase Therapeutic Tasks

1. *Develop working counseling relationship. Diversity consideration:* [Provide a particularly safe context of acceptance due to client's personal experience of marginalization as a gay male and his family's intergenerational history of marginalization as immigrant Polish Jews.]
   Relationship building intervention:
   a. Create opportunities for **I-Thou encounters** and experiencing; promote **independence and responsibility**.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Assess **freedom and responsibility** considering gay and Jewish family norms.
   Assessment strategies:
   a. Identify sources of **life meaning, purpose, and sense of freedom/responsibility**, with careful attention to his experience of being gay and Jewish.
   b. Assess for coping related to **death anxiety** and **existential angst** as well as capacity for **self-awareness**, including his awareness related to alcohol use.

Initial Phase Client Goals

1. *Decrease* client's attempts to avoid existential angst and responsibility to reduce problem drinking on the weekends.

(*continued*)

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Interventions:

a. Identify what purpose his heavy drinking is playing in his life and how it helps to avoid existential angst.
b. Encourage client to fully experience and acknowledge the fears and angst that client has been trying to escape through drinking.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* Ensure working with client rather than siding with his partner on the drinking issue.
   Assessment Intervention:
   a. Assess for increasing capacity for ability to readily and comfortably have I-Thou connection in session.

Working Phase Client Goals

1. *Increase* ability to identify significant sources of purpose and life meaning as well as ways he has "settled" to reduce sense of meaninglessness and drinking.
   Interventions:
   a. Encourage client to find sources of meaning that are worth living and struggling for and revisit abandoned dreams of being a lawyer and having a family.
   b. Affirm client's sense of self in relation to perceived threats as well as perceived life purpose.
2. *Increase* capacity to take responsibility for daily choices and overarching life direction to reduce drinking.
   Interventions:
   a. Encourage client to assume **responsibility** for drinking and its effects on his relationship and work life and how he allowed it to derail his dream of becoming a lawyer.
   b. Acknowledge **existential isolation**, including marginalization experience as gay male.
3. *Increase* capacity to **tolerate anxiety and existential** angst to reduce avoidance of life goals and dreams.
   Interventions:
   a. Encourage client to acknowledge and take **responsible** action in relation to existential anxieties related to his life direction.
   b. Encourage client to find **relationships** and/or communities in which he can feel a sense of belonging and responsibility.

Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity consideration:* Consider possible support resources in gay, Jewish, or Polish communities.
   Intervention:
   a. Help client identify ways to continue balancing freedom and responsibility in the face of existential challenges.
   b. Set clear, measurable goals for alcohol use and/or abstinence with means for identifying early warning signs of relapse.

Closing Phase Client Goals

1. *Increase* capacity to **authentically** experience and express **self** by living a life of **purpose and meaning** to reduce potential for relapse in drinking.

(*continued*)

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Interventions:

a. Encourage clients to make **choices** that enable him to embrace life, life purpose, and self by authentic connection and self-expression.
b. **Paradoxical interventions** to have client experiment with authenticity and facades to decrease tolerance of facades.

2. *Increase* ability to engage in **meaningful**, **intimate relationships** to reduce potential for relapse in conflict with partner.
   Interventions:
   a. Encourage client to develop the ability to readily have **I-Thou encounters** with significant others, friends, families, and others in the community.
   b. Encourage client to take **interpersonal risk** to be **authentic self** in relation to others.

Questions for Personal Reflection and Class Discussion

1. Describe an *I-Thou* encounter in your life. What was most significant about this experience? How did you make that type of connection?
2. Describe the balance of freedom versus responsibility in your life and in your family of origin. What cultural influences do you notice?
3. Describe your source of existential life meaning. How does this affect your thoughts, moods, and daily activities?
4. Describe your beliefs about death. What are your fears and/or hopes related to death? Where do these come from?
5. How do you experience the existential angst related to each person's fundamental aloneness in life?
6. Do you have any experience that relates to "the dark night of the soul"? How has that affected you?
7. What strengths does this approach have for working with diverse clients? What limitations?
8. How might this approach be useful with LGBTQ clients in the coming out process?

Online Resources

Associations and Training Institutes

Association for Humanistic Psychology
www.ahpweb.org

American Psychological Association, Division 32: Humanistic Psychology
www.apa.org/divisions/div32

International Society for Existential Psychotherapy and Counseling
www.existentialpsychotherapy.net

World Association for Person-Centered and Experiential Psychotherapy and Counseling
www.pce-world.org

Journals

International Journal of Existential Psychology and Psychotherapy
www.meaning.ca/ijepp.htm

Journal of Humanistic Psychology
www.ahpweb.org/pub/journal/menu.html

Videos

See the Theory in Action Videos at Cengagebrain.com

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CHAPTER

8

Gestalt Counseling and Psychotherapy

Learning is the discovery that something is possible.

—Fritz Perls

Lay of the Land

In a Nutshell: The Least You Need to Know

Pioneered by Fritz Perls—a dynamic therapist who is known for his often flamboyant and controversial style—and further developed by numerous others (Woldt & Toman, 2005; Yontef, 1993), Gestalt counseling is a phenomenological approach that emphasizes that people must be understood holistically and contextually—or, in Perls's native German, as a *Gestalt*. Similar to person-centered counselors, Gestalt counselors help people become more of who they really are by helping them to stop trying to be what they are not. Gestalt counselors achieve this end by enabling clients to develop present moment awareness of and direct contact with their internal world (including parts of the self that have been cut off) and the environment (significant others, society, etc.). Gestalt counselors believe neuroses and other problems develop when a person avoids direct contact with the environment or parts of the self. The in-session, present moment experiences facilitated by counselors enable people to reintegrate these cutoff parts of the self to create increasingly greater sense of *wholeness*.

Gestalt counseling methods are active, provocative, and experiential. Counselors in this approach interact as a whole person, using their emotional responses to clients as part of the process. Some Gestalt counselors use a more theatrical, cathartic style, while others use a more person-to-person approach (Yontef, 1993). Somewhat paradoxically, Gestalt theory encourages an "atheoretical" approach to counseling, meaning that rather than rigidly adhering to theory, practitioners focus more on the moment-by-moment flow of experience in the counseling relationship.

Through the Gestalt process of reintegrating cutoff parts of the self and increasingly making authentic contact with the environment, a person becomes a more vibrant and self-actualized person who is fully aware of and responsive to what is going on in his or her emotions, body, and relationships, resulting in a *natural flow of being*. Gestalt practitioners went through a more extreme "anything goes," antitheoretical phase in the 1960s but "sobered up" in the 1970s with a greater focus on a more supportive, dialogical engagement with clients (Yontef, 1993).

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Gestalt counseling and psychotherapy should not be confused with *Gestalt psychology*, which is a specific line of psychological research. Gestalt psychologists study how the brain organizes incoming sensory information into Gestalts to find and/or create wholeness, coherence, and patterns from the vast amount of incoming perceptual data. For example, in the line below, you are likely to see six boxes rather than 24 dots based on the *principle of proximity* (four dots near each other are perceived as one Gestalt) and *principle of closure* (four dots that outline a square are connected in the mind to form one):

.. ..
.. ..

Similarly, you are probably familiar with Rubin's vase, in which one can perceive either a vase or two faces looking at each other. Because of the ambiguity in this scenario, the mind can alternately perceive either the vase or the faces, depending on what it takes to be the *figure* and what it takes to be the *background*. Perls used these terms metaphorically to describe inner psychological processes. For example, needs, feelings, or desires can rise to the foreground of the mind (e.g., anxiety about an exam) and then recede (e.g., be superseded by a family crisis). Additionally, Perls adapted the principle of closure to refer to intrapsychic events, describing the need to have psychological closure to conflict, scenarios, relationships, and so on, as *unfinished business*. Laura Perls, Fritz Perls's wife, a Gestalt psychologist, objected to the metaphorical use of the term "Gestalt" as it applied to psychotherapy, but Fritz nonetheless used it to describe his work—and the name stuck.

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The Juice: Significant Contributions to the Field

If you remember one thing from this chapter, it should be …

Body Awareness

Gestalt counselors believe that every emotion has a physiological component (Perls, 1973; Polster & Poltser, 1973). When a person is cut off from the awareness of an emotion or part of the self, this becomes expressed in the body, usually as a tightening or dysfunction somewhere. Gestalt counselors are masters at picking up information from a person's body posture, fidgeting, tone of voice, and movements: "how a person sits ... tells so much about the contact he is willing to make" (Polster & Polster, 1973, p. 161). For example, a tight jaw may indicate holding back something a person wants to say and wringing of hands the suppression of what a person might want to do. Similarly, covering the abdomen may signal a sense of vulnerability, while stiff movements may be part of an attempt to hold oneself together. In the Gestalt view, the repressed and suppressed emotions that become expressed in the body is similar to Freud's view; however, Perls believed that awareness of the *process of repression* was the key to integration, whereas psychoanalysts believed that interpretation of the *content of repression* was the primary goal.

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Gestalt counselors help clients increase their awareness of their bodies and the emotions expressed through the body. Bringing a person's attention to body movements that are expressing repressed emotion is risky business: the mind has put a lot of energy into remaining unaware of the emotions, so you should proceed with caution and gentleness—or you may encounter quite a bit of resistance. Typically, Gestalt counselors approach bodily awareness by creating a *safe emergency*, which involves increasing the client's affective intensity while still supporting the client with affirmation (Yontef & Jacobs, 2000). In the case study at the end of this chapter, the counselor uses body awareness to help Monica more effectively manage trauma symptoms, such as flashbacks and nightmares.

Specific techniques for this include the following:

- *Where do you feel X in your body?* When a person is talking about a difficult emotion or situation, the counselor can ask, "Where do you feel the sadness [anger, hurt, disappointment, etc.] in your body?"
- *What would [body part/movement] say if it had a voice?* If the counselor has noticed a particular movement or body part that seems to be holding repressed emotion, the counselor could ask, "If that clenched fist could speak, what would it say?"
- *Exaggerate a movement:* If clients are having a difficult time understanding a particular body movement or expression, the counselor may direct them to exaggerate the movement to increase awareness: "Can you try to make yourself as stiff as you can? Exaggerate the stiffness. Feel and notice what emotions, memories, or thoughts emerge as you do this."

Try It Yourself

Identify a difficult emotion you have had in the past week. Either with a partner or alone on paper, use the above questions to explore where and how you experience it in your body. Notice how your understanding and experiencing of the problem shifts after answering the questions.

Rumor Has It: The People and Their Stories

Fritz Perls

Born in Berlin in 1893 to a Jewish middle-class family, Fritz Perls is the inspiration behind Gestalt counseling. He served as a psychiatrist in World War I in the German army, which later led to his introduction to Gestalt psychology and Laura Posner, whom he then married. He and Laura moved to Vienna to further study psychoanalysis, where he underwent analysis with Wilhelm Reich. As World War II loomed, he fled to the Netherlands and then South Africa, where he wrote his first book, *Ego, Hunger, and Aggression*. Soon after, he and Laura moved to New York, where, along with Paul Goodman, they opened the New York Institute for Gestalt Therapy in 1952. He left Laura and their two children to promote his therapy approach, eventually becoming affiliated with the Esalen Institute in California. Fritz was known for his highly provocative, controversial style in which he "provoked" clients to "grow up," offering a less supportive counseling relationship than most Gestalt counselors currently advocate.

Laura Posner Perls

An accomplished musician and artist and Gestalt psychologist by training, Laura Posner Perls spearheaded the development of Gestalt practices at the New York Institute of Gestalt Therapy. In contrast to her husband, Laura emphasized a supportive counseling relationship that emphasized interpersonal connection.

Erving and Miriam Polster

Well known for their book *Gestalt Therapy Integrated*, Erving and Mirian Polster (1973) were influential developers of Gestalt counseling, particularly the concept of contact boundaries.

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Big Picture: Overview of Counseling Process

Layers of Neurosis

The Gestalt counseling process aims to help people achieve a greater sense of wholeness, awareness, and aliveness. Perls (1973) describes the process of becoming more authentic as a five-part process that he likens to the peeling of an onion:

1. *Phony layer:* At this point, a person lives according to "shoulds" and habit, living an inauthentic life (e.g., an engaged woman who becomes fixated on having the perfect wedding, perfect dress, and perfect partner).
2. *Phobic layer:* In the phobic layer or stage, a person begins to become worried and fearful that something is amiss; he or she may feel helpless but work hard to keep his or her feelings hidden (e.g., the soon-to-be bride starts having second thoughts and doubts).
3. *Impasse layer:* At the point of impasse, a person begins to feel stuck, not knowing which way to go and thus becoming more open to seeking help, preferably from someone who will tell him or her the "right" answer (e.g., the bride-to-be begins asking for advice from family, friends, religious support persons, and/or a counselor).
4. *Implosive layer:* In this next phase, the phony layer begins to collapse, and the person feels empty inside and lost, which makes him or her more open to present moment awareness and experiences (e.g., the soon-to-be bride loses touch with why she wanted to get married and have a wedding in the first place and begins to ask herself and her fiance some difficult and discerning questions).
5. *Explosive layer:* In this final period, the person lets go of old pretenses, releasing bursts of new energy for authentic action (e.g., the young woman decides with a new sense of clarity that she wants to be married and designs a wedding that uniquely expresses who she and her partner are without relying on empty traditions or the latest fads).

Integration Sequence

The Polsters describe a similar change process that they call the *integration sequence* (Roberts, 1999):

- *Discovery:* In the discovery phase, the client comes to new realizations about the self in which new "figures" emerge from the ground. Often the counselor is instrumental in helping the client make discoveries through interventions and experiments.
- *Accommodation:* In the next phase, the client begins to accommodate this new perception and to behave in the world based on the discovery; the client may feel awkward and clumsy in his or her interactions.
- *Assimilation:* In this third phase, the once novel realization becomes more representative of who the client is: "feels like me."
- *Integration:* In the final phase, the new behavior fits seamlessly with the person's sense of self and seems effortless.

Making Connection: Therapeutic Relationship

Person of Counselor: Being Fully Human

The person of the counselor is the primary vehicle for change in Gestalt counseling (Perls, Hefferline, & Goodman, 1951; Yontef, 1993). The counselor uses their whole personhood to make a real and authentic contact with the counselor. More so than most of the forms of counseling, the counselor engages the client without professional pretense or role. Thus, counselors freely share their thoughts, perceptions, and feelings as they occur in session to rattle and awaken the client's authentic self. In short, the counselor is fully human, expressing a full range of emotion and openly admitting to mistakes and failings.

Here and Now, Presence, and Spontaneity

One of the primary experiences Gestalt counselors offer clients is their *presence* in *here-and-now* experiences (Polster & Polster, 1973). The counselor is fully in the present moment with the client, living in the *now*, where past and future fade away: "Since neurotic living is basically anachronistic living, any return to present experience is in itself a

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part of the antidote to neurosis" (Polster & Polster, 1973, p. 11). Polster and Polster further define the counseling process as "an exercise in unhampered living *now*," and therefore the counselor's primary role is to help clients more fully experience themselves—all aspects of themselves—as they arise moment to moment in session. Thus, counselors encourage clients to explore the tightness in their breathing, the spontaneous feelings that arise as they share what is on their mind, and whatever seems to bubble up during the counseling hour. The counselor does not try to "make sense of it all" or even connect early comments in session with contradictory later ones; instead, the focus is on becoming aware and fully experiencing and expressing the client's flow of consciousness.

Imperfect Role Model

Many people (including counselors) expect counselors to be near perfect, rarely getting angry, and having happily-ever-after relationships and everlasting good hair days. Many of us enter the field with the secret hope that maybe, just maybe, by reading enough books and learning how to help others through their problems, we won't have any of our own. It's tempting to hope for such bliss. Arguably, through popular books and media, the field frequently implies that such happiness and bliss are possible if you do enough positive self-talk, creative visualization, and feeling of emotion. But Gestalt counselors would argue that such problem-free living is a dangerous myth—so dangerous, in fact, that they are willing to be a role model for imperfection and thus a role model for the processes of integrating polarities. Thus, they do not hide behind a professional veneer, and instead they boldly go where many counselors will not. For example, they will freely comment on how a person's weight or grooming may be part of the reason that getting a date is difficult or will confront a person who was victimized as a child and who copes by feeling victimized by everyone and everything.

Dialogic Engagement

Drawing on the work of Buber (see Chapter 7), more recent Gestalt applications include *dialogic engagement*: "the dialogic view of reality is that all reality is relating" (Yontef, 1993, p. 33). Thus, growth happens "between" people and is best promoted in relationship rather through than individual awareness. The counselor's role is to engage the client fully, genuinely, and openly, willing to explore despair, love, anger, joy, humor, and sensuality. This dialogic openness requires discrimination on the part of the counselor to share personal feelings and information appropriately.

In dialogic approaches, the counselor uses the relationship as the primary context for making contact (Hycner & Jacobs, 1995). In the encounters between counselor and client, clients are able to develop awareness and differentiate self from nonself. Counselors use their authentic selves to help clients more clearly and safely experience what is self and nonself so that they can more freely experience here-and-now experiences.

Confirmation and Inclusion

Gestalt counselors believe "people become unique selves by the confirmation of other people" (Yontef, 1993, p. 36). *Inclusion* is considered the highest form of confirmation, when a person "feels into" the other's worldview while still maintaining a clear sense of self. The client practicing inclusion sees the world, life, and the client's situation as much as possible through the eyes of the client (Hycner, 1995). Since I know you'd ask, Yontef (1993) distinguishes inclusion from empathy by emphasizing that inclusion moves farther on the pole of really "feeling" another's world while simultaneously demanding greater awareness of self than empathy typically does. Generally, Gestalt counselors criticize empathy because it often leads to a confluence or blurring between self and other.

The Viewing: Case Conceptualization

Assessing the Field

Contemporary Gestalt counselors used Kurt Lewin's *field theory* as a primary tool for viewing clients and their lives (Parlett & Lee, 2005; Yontef, 1993). Similar to Gestalt psychology, field theory shares the view that a figure is intimately connected with its

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background. Field theory further posits greater and more dynamic interrelationships between figure and background than traditional Gestalt psychology. In field theory, the figure/ground are viewed as a systematic web of relationships that forms a unitary whole: "everything affects everything else in the field" (Yontef, 1993, p. 297). Field theory can be applied to a variety of counseling phenomena: the client as a whole, the counseling relationship, and how clients perceive their situations. In every case, the counselor is part of the field, affecting what is being observed; simply asking clients about their situations affects their situations (Parlett & Lee, 2005). Thus, counselors remain cognizant of how their questions and presence shape and affect clients' lived experience. Assessing the field requires investigation of the ever-fluctuating dynamics of the field and invites nondichotomous thinking, examining how each part affects the others (Lobb & Lichtenberg, 2005). For example, if a client complains that her partner has hurt her, the counselor explores not only how the client feels hurt but also how she may have contributed to her partner hurting her and how the client may have contributed to hurting her partner.

Questions for Assessing the Field

- What was your experience?
- How did you contribute to creating your experience?
- What were the experiences of others? How did you contribute to their experience?
- What other factors may have contributed to your experience? How might have you affected these factors?
- How is the sharing of this situation in the counseling encounter affecting your experience of this situation?

Contact Boundaries and Encounters

Gestalt counselors view each moment of lived experience primarily in terms of a form of *contact* between the self (organism) and outside world (others and environment; Perls, 1951; Yontef, 1993). If a person is able to make direct contact and authentically *encounter* the outside world, the person is living a full and authentic life. However, for a variety of reasons—such as early life lessons, fears, or social dictates—people avoid genuine contact to protect themselves. These *contact boundary disturbances* refer to distortions in perceptions of self or others.

An encounter involves a continuum of seven phases, beginning with initial perception, moving toward direct encounter, and ending in withdrawal. The human experience involves an endless ebb and flow of making contact with one person/object/idea and then withdrawing and then making contact and withdrawing from another, in an endless series of connections and disconnections. A person can avoid contact at any of the seven phases using specific resistance processes at each stage (Woldt & Toman, 2005):

Continuum Phase	Resistance Process	Example of Resistance
1. *Sensation/perception:* Organism perceives input from environment.	*Desensitization:* Failing to notice problems.	Ignoring increasing violence by partner in fights.
2. *Awareness:* One's lived experience becomes focused on the environmental sensation.	*Introjection:* Take in others' views whole and unedited.	Becoming what your parents wanted you to be.
3. *Excitement/mobilization:* The organism mobilizes to prepare for contact.	*Projection:* Assign undesired parts of self to others.	Rejecting sexual aspects of self and then perceiving others as "oversexed."

(*continued*)

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Continuum Phase	Resistance Process	Example of Resistance
4. *Encounter/action:* The organism takes action to engage the other.	*Retroflection:* Direct action to self rather than other.	Rather than creating conflict with others, focus criticism on self.
5. *Interaction/full contact:* A back-and-forth exchange happens; the self becomes part of "we."	*Deflection:* Avoid direct contact with another or self.	Working long hours to avoid spouse or avoiding own emotions.
6. *Assimilation/integration:* The organism takes in and integrates new information, behavior, etc.	*Egotism:* Not allowing outside to influence self.	Claiming to be "in love" but not being open to changing self to meet needs of relationship.
7. *Differentiation/withdrawal:* The organism withdraws from contact and returns to its individual state.	*Confluence:* Agree with another to the extent that boundary is blurred.	Agreeing with spouse to extent that one no longer allows self to have a divergent opinion.

When assessing clients, Gestalt counselors look for where their clients are "stuck" in the cycle of making contact and direct their interventions to encourage clients to make contact and complete the encounter cycle. In the case study at the end of this chapter, the counselor helps Monica address her avoidance of contact that stems from her childhood sexual abuse.

Polarities and Disowned Parts

Gestalt counselors view people as a never-ending sequence of *polarities* or complementary parts, as adult versus child, strong versus weak, loving versus hateful, and so on (Polster & Polster, 1973). When a person is rigidly polarized—always acts like an adult, is always strong, is always loving, and so on—they typically have disowned the opposite quality, such as childishness, weakness, or hatefulness. On the surface, this may not seem like much of a problem. The problem is that we are talking about members of the human species, who are human after all. Being human, each person experiences, at some level, the full range of human emotion. Thus, although a person may be very responsible in their day job, the ability to be playful like a child is an important counterbalance. A person may do extensive personal growth to feel emotionally strong but will still encounter difficult moments, loss, tragedy, and trauma and during these times will need to allow himself or herself to feel his or her weakness. Similarly, a person may engage in religious and spiritual practices to become more loving but may also experience loss, victimization, or trauma that elicits feelings of animosity and hate; that is part of the human experience. One doesn't need to *act* on this hate, but it is important to be accepting of having such feelings. When such feelings are *disowned*, the person must develop elaborate avoidance strategies that impede a person's ability to be fully who he or she is. Thus, the Gestalt counselors try to identify the polarities within a person that may be contributing to the presenting problem. Common problematic polarities include the following:

- Social self versus natural self
- Adult versus child
- Perfect versus failure
- Emotional versus logical
- Shallow versus deep
- Responsible versus carefree

In the case study at the end of this chapter, the counselor helps Monica, a grocery clerk who has recently begun reexperiencing trauma symptoms related to her childhood sexual abuse. One of the ways Monica had coped with the abuse was to be responsible, take care of herself, and avoid all risk, creating polarization. Healing for her will involve integrating carefree and trusting parts of herself.

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"Shoulds"

Gestalt counselors carefully listen for a person's use of "shoulds" to justify and explain their behavior and choices (Yontef, 1993). They believe that people who routinely organize their lives by doing what they "should" do rather than what they want to do, what they value, and so on, are not living authentically and are in fact *avoiding* taking existential responsibility for their lives (e.g., "I am doing what others have told me to do rather than decide for myself what I want to be doing, believe in"). They view "shoulds" as a form of *neurotic self-regulation*, meaning that the person is regulating emotions in unhealthy ways. Gestalt counselors confront persons living by "shoulds" and encourage them to make more authentic choices that are not fear-based or based on social pressure.

Unfinished Business

Like it sounds, *unfinished business* refers to any incompletely expressed feeling, which most often takes the form of resentment (Yontef, 1993). Gestalt counselors help clients identify unfinished business by playing the following game:

Unfinished Business Assessment Game

"For the next two (choose a time) minutes, I want you to list out as many things as you can that you are feeling resentful about. You can do this by starting your statements with: 'I resent ...' Just keep going and try to identify as many as you can, no matter how silly they may seem. Have fun with it, and we will talk about it when you are done. Any questions? Ready? Go."

Targeting Change: Goal Setting

Awareness

"In Gestalt, the only *goal* is *awareness*" (Yontef, 1993, p. 150). The counselor's primary goal is to help clients increase their awareness of their experiences so that they can make direct contact with the environment without resistance. The ability to be aware and in contact requires (a) organismic self-regulation, (b) acceptance of what is, and (c) the integration of polarities.

Organismic Self-Regulation

Perls (1973) described the long-term goal of counseling as helping clients to become *organismically self-regulating* rather than *shouldistic*, meaning ruled by cognition and lists of "shoulds." Yontef (1993) defines organismic self-regulation (and, yes, it is hard not to slip up and say orgasmic) as "choosing and learning happen holistically, with a natural integration of mind and body, thought and feeling, spontaneity and deliberateness" (p. 143). Vibrant and alive, such a person lives in a dynamic, responsive relationship with the environment, embracing the ebb and flow of life, including the more difficult moments, while responding authentically. An organismically self-regulated person has the courage to make "contact" with people and situations without having to rely on resistance processes to protect the self, trusting the self and life itself. This type of person takes responsibility for his or her relationship with others and the world and is able to *creatively adapt* to situations (Yontef, 1993). Furthermore, an organismically self-regulated person is *self-supporting*, meaning that this person can provide basic support for the self and does not need to manipulate others to meet personal needs.

Accepting "What Is": Paradoxical Theory of Change

Beisser (1970) posited a paradoxical theory of change that has been adopted by contemporary Gestalt counselors: the more one tries to change (and be who one is not), the more one stays the same. Thus, paradoxically, the long-term goals in Gestalt are less about correcting personal defects than about removing barriers to experiencing who one already is. Alternatively stated, the goal is to accept that what is "*is*," and to make peace with who and what one is. When a person is able to make contact with "what is," change

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spontaneously happens (Yontef, 1993). For example, many clients refuse to "make contact" with the "what is" of their body: they may believe they are not pretty or thin enough, be afraid of their sexuality or impulses, or be frustrated by pain or a debilitating condition. If the counselor can help clients make direct contact with "what is" by removing resistance barriers, clients' relationships with their bodies automatically transform to be more accepting, less fearful, and less judgmental. This paradoxical theory has been compared with Taoist and Buddhist "nondoing" and mindfulness practices (Smith, 1976).

Integration of Polarities

Another long-term goal in Gestalt counseling is *integrating polarities*, which involves accepting differences within the self and between self and the environment. In practice, integration takes the form of being less dogmatic, less rigid, and, quite simply, more complex as a human being because the person has accepted and integrated more aspects of the self. For example, if a man enters counseling defining his value in terms of his career achievements, the process of integration will involve accepting the "relaxed," "less-than-ideal," and less dominant parts of himself. Through this process, he may continue to excel at work but now also create time for a romantic relationship, hobbies, and "wasting time" with chitchat.

Initial and Working Phases

Early and middle phase goals in Gestalt counseling address the blockages to experiencing this integrated sense of self and generally address the presenting symptoms more directly. Examples are the following:

- Increase awareness of suppressed anger that fuels depression
- Decrease avoidance of difficult interpersonal exchanges and increase expression of feelings in situations where client fears negative rejection from others (or increase assertiveness with others)
- Decrease angry outbursts and hurtful comments with wife and children and increase ability to express more vulnerable emotions
- Increase ability to identify and separate own feelings from those of others and ability to act on these feelings

Closing Phase Client Goals

The closing phase client goals address the longer-term issues of (a) organismic self-regulation, (b) making contact with what is, and (c) integrating polarities. Examples are the following:

- Increase organismic self-regulation in marriage to increase emotional intimacy
- Increase acceptance of "driven" versus "relaxed" polarities to create better work-home balance
- Increase capacity to make direct contact with family of origin
- Increase ability to accept "what is" related to loss of mother

The Doing: Interventions

Body Awareness (see "The Juice")

Gestalt Experiment and Empty Chair

A Hollywood favorite for mocking counselors, the Gestalt empty chair involves having clients pour out their hearts to an empty chair and then turn around and respond from the empty chair, having a conversation with themselves. Although this technique looks strange and even silly from the outside, when you are the one speaking, it is rarely a joke—it is challenging and powerful. This technique enables clients to have conversations with people and parts of themselves that they would otherwise never be able to have.

Gestalt counselors use the empty chair and similar Gestalt experiments because they prefer action over talk. Thus, their characteristic technique is the *Gestalt experiment*,

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which involves inviting the client to take action in the room by creating a "safe emergency" (Polster & Polster, 1973). An experiment may involve having an empty-chair conversation by speaking aloud to an imagined person in an empty chair, sharing things the person is too afraid to say to the imagined person directly. For example, if a person is angry with his boss but afraid to speak to her, the counselor may ask him to speak aloud what he has been too afraid to say to this person. The purpose of this empty-chair encounter is *not* to rehearse for an actual confrontation or to "vent" feelings but rather "to relate to reality out there by expressing his needs at that moment in time" and experience "in the present what it is like for him to flow from awareness to experimental action" (Polster & Polster, 1973, p. 235). This safe opportunity to experience acting and speaking from one's immediate lived experience makes it easier and more likely that the client will do so outside the session. In most cases, the person's actions outside the session will not be a replica of what occurred in counseling (most of us tone it down in the real world). The Gestalt experiment is *not* an "acting out" of emotion but rather a safe context for experimenting with authentic expression.

Gestalt experiments can take many forms (Polster & Polster, 1973):

- Enactment of unfinished business situation from the distant past
- Enactment of contemporary unfinished business situation
- Enactment of a characteristic (desired or undesired)
- Enactment of a polarity (both sides)

Yontef (1993) lists the purposes of experiments, including:

- To expand a person's repertoire of behaviors outside the session and stimulate experiential learning
- To create conditions in which the client can see life as his or her own creation and also take ownership of the counseling process
- To complete unfinished business, overcome blockages in awareness, and integrate polarities
- To stimulate a sense of strength, competency, self-support, and responsibility

Steps to Successfully Stage an Experiment

1. **Identify Focus:** Through dialogue, the counselor and client identify areas of unfinished business, polarities, resistance, and so on (e.g., unexpressed anger at mother).
2. **Initiate Experiment:** The counselor then invites the client into the experiment by specifically *directing* the client to experiment by speaking to an empty chair, saying something aloud, or taking physical action of some form (e.g., "I want you to pretend for a moment that your mother is in the chair next to you. Go ahead and speak to her, saying those things you wish you would have said the last time you saw her").
3. **Focus Experiment:** During the experiment, the counselor may encourage the client to address specific areas or take certain actions (e.g., "Why don't you address what happened during the divorce, too?").
4. **Experience the Experiment:** After the experiment, the counselor focuses on helping the client identify the here-and-now experiencing of the experiment (e.g., "What were you feeling inside when you were talking to your mother? Did any particular part of your body react? What are you feeling like, now that you said that aloud?").

Try It Yourself

Find a partner and take turns facilitating a Gestalt experiment using these steps. Afterwards, discuss what parts were the most useful and what was most challenging.

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Semantics and Language Modification

Gestalt counselors direct clients to modify the language to highlight their autonomy, choice, and responsibility. Common examples include the following:

- *Questions to statements:* Gestalt counselors ask clients to change questions to statements because often questions are disguised statements or demands for support from others (Yontef, 1993).
- *"I" Versus "You" or "It" statements:* Rather than describing someone else as the agent in a situation ("*you* made me do X") or in a passive voice ("it just makes me feel X"), Gestalt counselors have clients rephrase a statement beginning with "I": "I decided to do X," or "I chose to feel X."
- *"Choose" Versus "Can't":* When a client says I "can't" but there is an element of choice, the counselor has the client restate his or her position acknowledging his or her choice: "I choose to spend time at work to make a deadline rather than come home on time."
- *"Want" Versus "Have To":* Similarly, Gestalt counselors have clients clearly distinguish between "having to do something" (which is ultimately extremely rare) and wanting to do something: "I want to pay taxes to avoid being pursued by the IRS" rather than "I have to pay taxes." By constantly highlighting that we all have free choice in most all life circumstances, *choose* increases a person's sense of freedom, will, and responsibility even if the life choices remain the same ("I am going to choose to keep paying taxes").
- *"But":* Another word Gestalt counselors watch for is "but," which is typically followed by excuses, polarity, or a double message. Instead, clients are encouraged to develop integration by replacing "but" with "and."

Staying with Feelings

To increase awareness, Gestalt counselors often encourage clients to "stay with" difficult feelings, coaching them through the continuum of contact: sensation, awareness, excitement, encounter, integration, assimilation, and withdrawal (see the section "Contact Boundaries and Encounters"). The counselor encourages the client in each phase to move through resistances to have direct experiences. Much like the experiment, encouraging clients to stay with feelings helps them develop the skills and courage to do this outside of session.

Dream Work

Gestalt counselors use a unique approach to dreams. They see them as attempts to integrate parts of the self and/or as an existential message, and the counselor is not assumed to know the true interpretation better than the client (Yontef, 1993). Gestalt counselors view each character in the dream as a part of the self. For example, if a person is being chased in the dream, both the pursuer and the one fleeing are viewed as different aspects of the self. The counselor and client can explore how these parts interact, what each might represent, and how they have been neglected or emphasized in the person's life.

Putting It All Together: Gestalt Case Conceptualization and Treatment Plan Templates

Theory-Specific Case Conceptualization: Gestalt

Use the prompts below to develop a theory-specific case conceptualization; the case study at the end of the chapter provides an example.

- *Assessing the Field:* Describe the client's field (experience) and background (broader context, relationships, etc.) and the dynamic relationship between the two.
- *Contact Boundaries and Encounters:* Describe typical contact boundary pattern:
  - *Desensitization:* Failing to notice problems
  - *Introjection:* Take in others' views whole and unedited

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  - *Projection:* Assign undesired parts of self to others
  - *Retroflection:* Direct action to self rather than other
  - *Deflection:* Avoid direct contact with another or self
  - *Egotism:* Not allowing outside to influence self
  - *Confluence:* Agree with another to extent that boundary blurred
- *Polarities and Disowned Parts:* Describe polarities and disowned parts, which may include:
  - Social self versus natural self
  - Adult versus child
  - Perfect versus failure
  - Emotional versus logical
  - Shallow versus deep
  - Responsible versus carefree
- *Shoulds:* Describe problematic shoulds that relate specifically to the problem and those that more generally organize the client's life.
- *Unfinished Business:* Identify any unfinished business, such as resentments and guilt, that client has yet to deal with.

Treatment Plan Template: Gestalt

Use this treatment plan template for developing a plan for clients with depressive, anxious, or compulsive types of presenting problems. Depending on the specific client, presenting problem, and clinical context, the goals and interventions in this template may need to be modified only slightly or significantly; you are encouraged to significantly revise the plan as needed. For the plan to be useful, goals and techniques should be written to target specific beliefs, behaviors, and emotions that the client is experiencing. The more specific, the more useful it will be to you.

Treatment Plan

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration:* [Describe how you will specifically adapt your approach to be sensitive to client diversity when developing the counseling relationship; this may include respecting cultured and gendered norms for emotional expression.]
   Relationship building intervention:
   a. Confirmation of client's **unique self** while counselor is also expressing authentic self.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* [Describe how you will specifically adjust assessment of emotions, emotional expression, and authenticity based on cultural, socioeconomic, sexual orientation, gender, and other relevant norms.]
   Assessment strategies:
   a. Assess client's ability to make **authentic contact** with others and environment.
   b. Identify **polarities**, **disowned parts**, "**shoulds**," and **unfinished business**.

Initial Phase Client Goals

1. *Increase* tolerance of difficult emotions and **unwanted parts of self** that fuel crisis to reduce [specific crisis symptoms].
   Interventions:
   a. **Body awareness** exercises to help client identify and more effectively manage crisis emotions.
   b. Encourage client to "**stay with**" **difficult feelings** that fuel crisis and coach client through experiencing these emotions to defuse crisis.

(*continued*)

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Working Phase of Treatment

Working Phase Counseling Tasks

1. *Monitor quality of the working alliance. Diversity consideration:* [Describe how you will adapt relationship to be responsive to gender and cultural forms of **emotional expression** and **contact norms**.]
   Assessment Intervention:
   a. Monitor frequency of **here-and-now experiencing**, willingness to tolerate differences between self and other, and **authentic expression of self**; use Session Rating Scale.

Working Phase Client Goals

1. *Increase* **integration of polarities** between [X] and [Y] to reduce [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. **Gestalt experiments and empty-chair** exercises to facilitate awareness and integration of polarities.
   b. **Modify language** to allow for both acceptance of polarities.
2. *Increase* ability to **self-regulate** in [X: specific context, relationship, problem, etc.] to reduce [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. Coach client on **staying with difficult feelings** to increase ability to self-regulate.
   b. **Gestalt experiments** with alternative behaviors to increase self-regulation skills.
3. *Increase* ability to **accept** "**what is**" in relation to [unchangeable situation] to reduce [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. **Dream analysis** to better understand resistance to and rejection of "what is."
   b. **Language modification** to reduce "shoulds" in relation to "what is."

Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity consideration*: [Describe how you will access resources in the communities of which they are a part to support them after treatment ends.]
   Intervention:
   a. Increase capacity for **organismic self-regulation** in relation to potential future stressors.

Closing Phase Client Goals

1. *Increase* capacity to **self-regulate** and expand **here-and-now experiencing** to be primary mode for daily living in all contexts to reduce potential for relapse in [specific symptom: depression, anxiety, etc.].
   Interventions:
   a. Increasingly challenging **Gestalt experiments** to integrate spontaneity into all aspects of daily living.
   b. **Dream work** to identify more subtle resistance and **polarities** that impeded full authenticity in daily living.
2. Increase **self-regulation** and **authentic expression of self** in intimate relationships while simultaneously allowing for another's authenticity to reduce potential for relapse in [specific symptom: depression, anxiety, etc.].

(*continued*)

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Interventions:

a. **Empty-chair experiments** to develop awareness and skills for authentic relating.
b. **Gestalt experiments** in significant relationships that help to build capacity for authentic intimacy.

Research and the Evidence Base

Similar to person-centered (Chapter 6) and existential (Chapter 7) counseling, little systematic research has been conducted on Gestalt counseling outcomes, aside from the effectiveness of the empty-chair technique (Wagner-Moore, 2004). Again, the most robust findings have been that the qualities of the counseling relationship espoused by humanistic counselors have been found to be one of the most significant common factors that predict positive outcome in all forms of counseling (see Chapter 1).

Attributed as much to the personal style of Perls as to the philosophical foundations of humanism, little research has been conducted on the process or outcomes of Gestalt counseling, with one significant exception: the empty-chair, or "two-chair," technique (Wagner-Moore, 2004). Greenberg and colleagues (Clarke & Greenberg, 1986; Greenberg, Elliott, & Lietaer, 1994; Greenberg & Rice, 1981) have specifically studied the two-chair technique separately from the Gestalt approach. In a series of studies comparing the two-chair technique to person-centered empathetic responding, participants in both studies reported a greater depth of experiencing and more shifts in awareness (Greenberg & Dompierre, 1981; Greenberg & Rice, 1981). Furthermore, another study that compared the two-chair technique to cognitive-behavioral problem solving and a no-treatment control group found that the two-chair technique was superior to both. Several other studies have provided preliminary support for using the two-chair technique with anger and unfinished business issues. Much more work needs to be done to explore the change mechanisms and outcomes of Gestalt work.

Tapestry Weaving: Working with Diverse Populations

Cultural and Ethnic Diversity

Gestalt therapy is an approach that is used throughout Europe, North America, parts of South America, Asia, and Australia (O'Leary, 2013). Its wide reach can be partially attributed to Perls himself, who lived in Germany, Holland, South Africa, the United States, and finally Canada. Similar to other phenomenological approaches, Gestalt's emphasis on the individual's subjective lived experience enables practitioners to adapt the approach to diverse populations; however, counselors need to carefully consider the embedded values and assumptions about emotional expression and individuality to ensure that these are not inadvertently forced onto clients.

Contemporary Gestalt counselors integrate cultural considerations as part of their assessment of the figure/ground and "field" in which the client lives and works, in order to increase a person's awareness of how culture is a part of their daily experience of self and environment (Fernbacher & Plummer, 2005). Emphasis is placed on awareness of the counselor's personal positioning as human in a diverse and multifaceted culture, and on considering how these factors affect how the client experiences the counselor. Additionally, the Polsters were some of the earliest advocates for women, identifying the processes through which society demands that women disown parts of the self for the sake of others and politeness (Roberts, 1999).

Asian Americans and Gestalt Empty Chair

Cheung and Nguyen (2012) have explored the possibility of using the Gestalt empty-chair technique with Asian Americans. In adapting this intervention for working with

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Asians, they identified four characteristics of the population observed in research that they used to frame their approach:

1. Connecting the meaning of shame in therapeutic interventions
2. Avoiding the loss of "face" in confronting relatives and friends
3. Using alternative and complementary means to replace traditional therapy and direct confrontation
4. Using inner control and spirituality in resolving interpersonal guilt and conflict (Cheung & Nguyen, 2012, p. 54)

The empty-chair technique allows some Asian clients to more easily express their emotions because they do not need to make direct eye contact (with counselor or family member) and they need not fear losing face or being disrespectful.

Cheung and Ngyuen (2012) describe three steps to using the Gestalt chair with Asian Americans.

Step 1: Introduce the function of the empty chair: Introduce the chair as an "exercise" with a concrete function or goal, such as helping to address a conflict with a specific person. Clients should never be forced to use the chair, but instead encouraged to explore any concerns or resistance if it is voiced. Often, if the conflict is with an authority figure, Asian clients will mention that it feels disrespectful; in such cases, the counselor can describe how the chair exercise will allow them to safely explore the conflict without being disrespectful or without anyone losing face.

Step 2: Engage the client in the therapeutic process: Once the client has agreed, the counselor's job is to facilitate the change process in a form that is comfortable to the client. In addition to more traditional empty-chair techniques, adaptations that may work for Asian American clients include:

1. Imagining the chair: Starting without an empty chair; simply imagining the person is in the room.
2. Using imagery: Having the client imagine a specific time in the past when there was conflict.
3. Using direct dialogue: Once the client begins to talk to the person, directing the client to talk to the chair.
4. Role-playing: If the client does not want to look at the chair, the client can speak to the counselor instead.
5. Swapping chairs: The counselor can pretend to be the client in the dialogue, and the client can sit in what would otherwise be the empty chair; then counselor and client can swap chairs again, allowing the client to speak from his/her own position in the next round.
6. Telling one thing: Have the client identify one thing that the other person might say (that the client wishes the other would say, something that might be helpful, etc.) and then also invite the client to respond to this "one thing."
7. Telling a story: Have the client and the imagined other (role-played by counselor) tell a story together.
8. Native language: If the client has a native language, speak for the imagined other in that native language and respond in that language.

Step 3: Debriefing: After finishing one or more of the above exercises, the counselor should take time to reflect on what happened using a transition statement, such as, "Now, let's come back to this room with just you and me. What was that experience like for you?" (Cheung & Nguyen, 2012, p. 58). With Asian American clients, it may be helpful to also include concrete follow-up questions, such as: What did you learn from this exercise? Can you see a way to apply this knowledge to future situations?

Gestalt Counseling in Australia

Introduced to Australia in the 1970s, Gestalt counseling resonates with many aboriginal views and ways of life (O'Neil, 2013). Both Gestalt methods and aboriginal culture strive to create wholeness by cultivating harmony with the environment (i.e., field). The aboriginal view of the organism in the environment is a rich and concrete example of

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what Gestalt counselors refer to when they describe field theory and figure/ground distinctions. Australian contributions have included raising awareness of how a person's relationship to the physical environment and ecology has significant implications in the mental health and overall wellness of the individual (O'Neil, 2013). This "greening of psychology" or eco-psychology approach invites counselors and clients to consider the natural cycles of growth and decay in the physical world and how these also occur in the psycho/emotional world as well. This view complements many traditional Gestalt concepts that emphasize fully embracing unwanted realities and engaging life's paradoxes and complexity.

Similarly, Australian counselors have applied Gestalt theory to equine therapy methods (O'Neil, 2013). In this modality, the human-horse-human encounter offers the potential to shift and expand authentic experiencing to include the natural world. Equine therapy offers the possibility of an interspecies encounter and connection that provides a new context from which to understand human experiences within the broader context of nature. This type of encounter typically brings forth a more civilized and humane understanding of oneself and one's role in the world.

Sexual Identity Diversity

Gestalt counselors report on several case studies using the approach with sexual minority individuals, particularly gay men (Beane, 1981; Kondas, 2008; Silverstein, 2011). Because it works from within the client's lived reality and unapologetically encourages clients to be authentic, many find it an excellent approach for working with sexual minorities who often feel that their genuine experience of themselves is not acceptable to self or others.

Elements of Gestalt Counseling with Gay Men Coming Out

Beane (1981) describes how he uses the Gestalt process to work with gay men coming out. The coming out process fundamentally involves developing a positive gay identity, which Beane describes as a lifelong process that is more similar than different across individuals.

Initial Awareness Work As is typical in Gestalt work, the initial phases of working with gay men coming out involves increasing the client's awareness of how he operates in the world. This involves a nonjudgmental acceptance of thoughts, feelings, sensations, and desires. With gay men, this process typically involves identifying introjected beliefs related to being gay, such as:

- *Homophobic introjection:* The belief that homosexuality is fundamentally wrong: illegal, an illness, or immoral (Beane, 1981). This introjection results in disowning one's innate sexual experiences and thus being less authentically alive.
- *Gay male stereotypes:* In addition to homophobic introjects, most gay men also have negative introjects about gay men (Beane, 1981). These introjects may include a belief that gay men are effeminate, hate women, or want to be women. Some may even have stereotypes about professions that are appropriate for gay men: designers, counselors, nurses, etc.
- *Masculinity:* Another set of introjects typically addresses values about masculinity. Many gay men have the same limited definition of masculinity ascribed to by heterosexual males: breadwinner, emotionally independent, aggressive, competitive, etc.
- *Sexual values:* Gay men, especially those with strict religious backgrounds, also frequently struggle with introjects related to sex and monogamy (Beane, 1981).

Making Contact Gestalt counseling with gay men involves making authentic contact between counselor and client, a connection in which both accept the other as he/she is without judgment. Contact is more likely to occur when the counselor expresses empathy, caring, and acceptance of the client's reality, beliefs, and experiences (Beane, 1981). For gay men in the coming-out process, making contact can be profound and life altering, since many have limited experience with such full acceptance of who they are.

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Awareness of Body and Emotions Many gay men learn to cope in a heterosexist world by denying their bodily sensations and emotions. Many numb the physical experience of sexual excitement for other men in an attempt to erase awareness of these socially inappropriate experiences (Beane, 1981). The coming-out process involves learning to honor and trust the process of experiencing sensations, desires, and emotions as they arise in the present moment, rather than escaping into the mind. Gestalt counselors can help gay men reconnect with these denied sensations and emotions by encouraging awareness in these areas.

Support Finally, counselors can help gay men in the coming-out process by increasing their self-support and environmental support (Beane, 1981). A person who is self-supportive is able to accept himself, others, and life as it is and feel okay with self, others, and things as they are. As part of this acceptance, the person may decide that action is needed to care for the self, such as a gay man leaving a relationship, job, or community that does not accept him for the way he is; but such action is not taken in anger or revenge but done so with awareness and as a conscious decision. Self-support also involves the individual providing all that is necessary—whether finding it from within or by seeking it in the environment—to facilitate authenticity and personal growth. For gay men, this often involves finding supportive friends and communities. Beane (1981) notes that many gay men report that meeting another man with a positive gay identity is one of the most helpful and powerful experiences for developing a positive identity themselves. Thus, group counseling experiences can be particularly powerful for this population.

Gestalt Counseling for Gay Male Survivors of Domestic Violence

Kondas (2008) describes a seven-stage model for working with gay male survivors of domestic violence. He recommends using Gestalt multiple mini-"explosions" to help gay survivors increase their awareness and heal from trauma. Gestalt explosion requires authentic contact between counselor and client to create a context of safety for experiencing intensive and painful emotions without retraumatization.

Stage 1: Implosive, trauma-related boundaries In stage one, the client uses dissociation, obsession, and soothing self-talk to manage and avoid the trauma experiences (Kondas, 2008). The client may deny both anger and feelings of love toward the batterer and have difficulty setting appropriate boundaries.

Stage 2: Grief explosion and self-directed anger In this stage, the survivor feels the anguish of loss as well as a sense of anger at the self for having feelings of love for the perpetrator. The dominant introject is often "I should not feel love for my abuser" (Kondas, 2008, p. 65).

Stage 3: Implosive withdrawal/retreat from phobic layer In stage three, the survivor strives to avoid trauma-related triggers, fears, and emotions. There is a physical and emotional contraction to facilitate healing and recuperation as well as protect the self from further harm.

Stage 4: Other-directed rage explosion In stage four, the client begins to express anger, but initially not at the perpetrator, but rather at past perpetrators of hate crimes or childhood abuse. This phase involves eventually being able to access and experience anger at the perpetrator. In this phase, the Gestalt counselor may encourage the client to physically act out the anger by hitting a pillow or destroying a tennis racket (Kondas, 2008).

Stage 5: Explosive discharge of abandonment fears; existential dread Stage five may occur close in time with stage 4. As the client allows himself to become fully aware of the abuse, he may become not only become angry (stage 4) but also become more fully aware of his vulnerability (stage 5). Fear and grief can surface in new ways in this stage.

Stage 6: Final implosive withdrawal, but less symptomatic If in stage 5 the client was able to truly discharge his fears related to the trauma, the client should exhibit fewer

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PTSD symptoms. The client may cycle through the earlier stages until the symptoms appear less and less.

Stage 7: Joy explosion In stage seven, the client is able to take new action and set new boundaries as well as develop more positive self-introjects and forms of self-expression.

Gestalt Case Study

Monica, a 27-year-old Mexican American, has come to counseling because she began to have flashbacks and nightmares about her sexual abuse by her brother when she was 7 years old. She works as a grocery store clerk, and the nightmares started after one of her coworkers was raped in the parking lot one night. She reports that her parents minimized what happened by saying that he was just "exploring," but they agreed to not leave the two alone because of the issue. Her brother has never apologized. Over the years, Monica coped by being a "good girl" and playing by all of the rules and avoiding any type of risk. She had to work as soon as she turned 16 and started supporting herself as soon as she graduated from high school. She maintains her same friends from high school and has dated a few times but has not committed to anyone seriously after her high school sweetheart cheated on her with her best friend.

Case Conceptualization: Gestalt

This case conceptualization was developed by selecting key concepts from "The Viewing: Case Conceptualization" section of this chapter. You can use any of the concepts in that section to develop a case conceptualization for this or other cases.

Assessing the Field

In assessing the field, AF (adult female) has a pattern of being and feeling victimized by others. It is likely that her unresolved issues related to being abused by her brother contributed to her choosing a boyfriend who eventually cheated on her and/or resulted in behaviors on her part that contributed to the problems in their relationship. Furthermore, her current pattern of avoiding risks, especially those related to relationships, is likely to continue to push others away from her.

Contact Boundaries and Encounters

AF has a long history of *deflection* and avoiding direct contact with others that can be traced back to her childhood sexual abuse. This pattern of deflection has become disabling in her social life.

Polarities and Disowned Parts

In order to cope with her abuse, AF has polarized, trying to become the "good girl" by avoiding risks, staying out of trouble, and always being responsible. Her avoidance of risk has truncated her development by her choosing to work full-time rather than go to college and avoiding dating relationships in which she might get hurt.

"Shoulds"

AF has a long list of "shoulds": "I should not make a big deal of what happened," "I should always play it safe and work at a safe job and avoid relationships where I might be hurt," "I should forgive and forget," and so on. These "shoulds" have kept her from living authentically in any area of her life.

Unfinished Business

AF has significant unfinished business with her brother and parents related to the abuse. The whole family has continued to go on like nothing ever happened but innocent child play, but AF feels otherwise. She has been too afraid to debunk this family myth but will likely need to speak her truth in order to live a more authentic life.

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Treatment Plan: Gestalt

Initial Phase of Treatment

Initial Phase Therapeutic Tasks

1. *Develop working counseling relationship. Diversity consideration:* Adapt **emotional expression** and use *personalismo* to connect with AF as a Latina.
   Relationship building intervention:
   a. Confirmation of client's **unique self** and **validating her abuse experience** while counselor is also expressing authentic self.

2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Adapt assessment of emotions, emotional expression, and authenticity to her family and Mexican American norms.
   Assessment strategies:
   a. Assess client's ability to make **authentic contact** with others and environment.
   b. Identify **polarities**, **disowned parts**, "**shoulds**," and **unfinished business**, especially as they relate to abuse.

Initial Phase Client Goal

1. *Increase* tolerance of difficult emotions and **unwanted parts of self** that fuel crisis to reduce flashbacks and nightmares.
   Interventions:
   a. **Body awareness** and grounding exercises in session to help client identify and more effectively manage crisis emotions; developing grounding exercises in the present moment to help out of session.
   b. In structured in-session exercises, encourage client to "**stay with**" **difficult feelings** that fuel crisis and coach client through experiencing these emotions to defuse crisis out of session.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* Adapt relationship to be responsive to Latina **emotional expression** as well as her need for safe **contact** due to abuse history.
   Assessment Intervention:
   a. Monitor frequency of **here-and-now experiencing**, willingness to tolerate differences between self and other, and **authentic expression of self**; use Session Rating Scale.

Working Phase Client Goals

1. *Increase* **integration of polarities** between "good girl" and "bad girl" to reduce shame related to the abuse and her fear of taking risks and being hurt or failing.
   Interventions:
   a. **Gestalt experiments** and **empty-chair** exercises to facilitate awareness and integration of polarities.
   b. **Modify language** both to allow for acceptance of polarities and to relax her fear of being "bad."

2. *Increase* ability to **self-regulate** in relationships to reduce avoidance of intimate relationships.
   Interventions:
   a. Coach client on **staying with difficult feelings** related to rejection and being hurt to increase ability to self-regulate.

(*continued*)

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b. **Gestalt experiments** related to talking with men with alternative behaviors to increase self-regulation skills.

3. Increase ability to **accept** "**what is**" in relation to family's denial of abuse to reduce fear of risk and being hurt.
   Interventions:
   a. **Gestalt experiments** to practice raising the issue with her parents and/or brother; discuss pros and cons of doing these in real life and identify best strategies for resolving this old business.
   b. **Language modification** to reduce "shoulds" in relation to "what is."

Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity consideration:* Identify potential support resources in her church, family, and/or Mexican American community.
   Intervention:
   a. Increase capacity for **organismic self-regulation** in relation to potential future stressors.
2. Include strategies for early detection of trauma issues resurfacing.

Closing Phase Client Goals

1. *Increase* capacity to **self-regulate** and expand **here-and-now experiencing** to be primary mode for daily living in all contexts to reduce potential for relapse of trauma symptoms, such as nightmares, relationship avoidance, and flashbacks.
   Interventions:
   a. Increasingly challenging **Gestalt experiments** to integrate spontaneity into all aspects of daily living.
   b. **Dream work** to identify more subtle resistance and **polarities** that impeded full authenticity in daily living.
2. *Increase* **self-regulation** and **authentic expression of self** in intimate relationships while simultaneously allow for another's authenticity to reduce avoidance of intimate relationships.
   Interventions:
   a. **Empty-chair** experiments to develop awareness and skills for authentic relating to friends, family, and intimate partners.
   b. **Gestalt experiments** in significant relationships that help to build capacity for authentic intimacy.

Questions for Personal Reflection and Class Discussion

1. How do you feel emotions in your body typically, as:
   - anxiety?
   - sadness?
   - anger?
   - embarrassment?
2. What possibilities do you see with the Gestalt approach to being "fully human" and an "imperfect role model" with clients? What potential problems might arise?
3. How might a counselor's spontaneous expression of self be a strength and potential problem when working with diverse clients?
4. Describe an experience you had that felt like an authentic encounter of the environment.

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- What facilitated this process?
- What was it like to experience authenticity?
- What inhibits these experiences in your life?

5. What challenges in helping clients experience authenticity might counselors have when working with clients who are different from themselves?
6. How might authenticity look different across cultures?
7. What possibilities do you see for using the Gestalt empty chair with clients? What are the potential challenges?

Online Resources

Associations and Training Institutes

Association for Humanistic Psychology
www.ahpweb.org

American Psychological Association, Division 32: Humanistic Psychology
www.apa.org/divisions/div32

Esalen Institute, Big Sur California
www.esalen.org

New York Institute for Gestalt Therapy
www.newyorkgestalt.org

Gestalt Institute of Cleveland
www.gestaltcleveland.org

Pacific Gestalt Institute
www.gestalttherapy.org

Gestalt Institute of San Francisco
www.gestaltinstitute.com/enter

Gestalt Institute of the Rockies
www.gestaltoftherockies.com

The Gestalt Therapy Institute of Philadelphia
www.gestaltphila.org

World Association for Person-Centered and Experiential Psychotherapy and Counseling
www.pce-world.org

Journals

British Gestalt Journal
www.britishgestaltjournal.com

Gestalt Review
www.gestaltreview.com

International Gestalt Journal
www.gestalt.org/igipromo

Journal of Humanistic Psychology
www.ahpweb.org/pub/journal/menu.html

Journal of the World Association for Person-Centered and Experiential Psychotherapy and Counseling
www.pce-world.org/pcep-journal.html

Videos

See the Theory in Action Videos at Cengagebrain.com.

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*Asterisk indicates recommended introductory readings.

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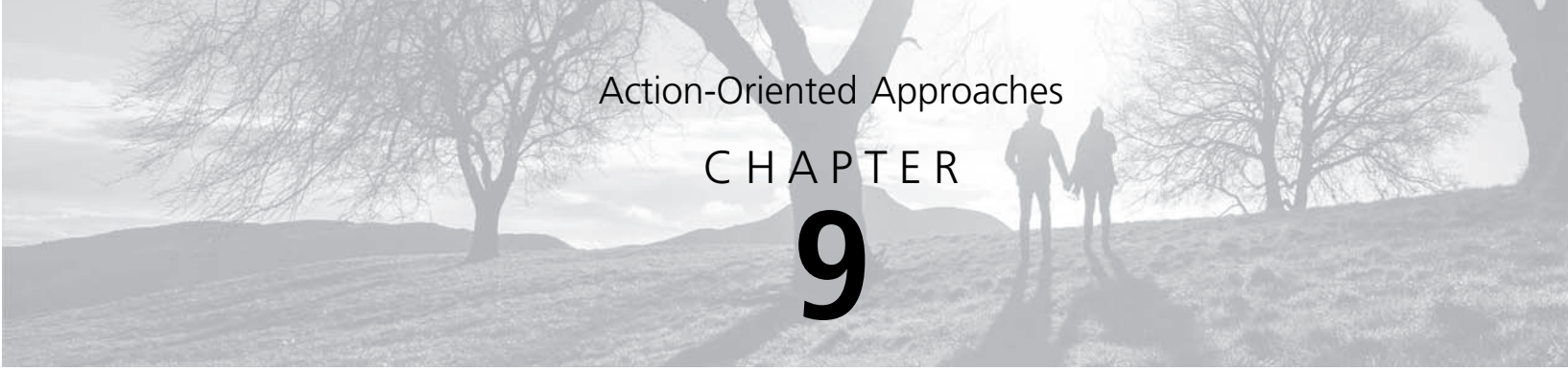

Action-Oriented Approaches

CHAPTER

9

Foundational Cognitive-Behavioral Approaches

When people understand or have insight into how they needlessly disturb themselves and create unhealthy and dysfunctional feelings and behaviors, that insight often will help them change and make themselves less disturbed. But understanding and insight are not enough. In order to significantly change themselves, they almost always have to pinpoint their irrational philosophies and work at changing them to more functional and self-helping attitudes. They can do this in a number of cognitive, emotive-evocative, and behavioral ways.

—Ellis (2003, p. 220)

Lay of the Land

Behavioral, cognitive, and cognitive-behavioral approaches are a group of related counseling methods that emphasize using active techniques and psychoeducation to achieve changes in behaviors, cognition, and affect. They are favored by third-party payers, such as insurance, because they are brief, target medical symptoms rather than broader personality issues, and have a strong research tradition. These approaches can be divided into three streams of practice:

- *Behavioral approaches:* Using classical conditioning, operant conditioning, and social learning theory, behavioral approaches focus on analyzing and intervening on observable, measurable behaviors; in this approach, thought is conceptualized as a covert behavior that operates according to standard behavioral principles (Skinner, 1974). The evolution of behavioral approaches occurred in three waves (Hayes, 2004):
  - *The first wave of behaviorism:* The original "pure" behavioral approaches based on classical conditioning, operant conditioning, and social learning theory (see "The Viewing: Case Conceptualization").
  - *The second wave of behaviorism:* Integration of cognitive approaches with behavioral, which, before the 1980s, was a separate stream of research and practice.
  - *The third wave of behaviorism:* In the 21st century, mindfulness approaches are transforming behavioral practices to use compassionate acceptance of thoughts and feelings to paradoxically promote change.

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- *Cognitive approaches:* Developed independently from behavioral approaches by Aaron Beck, cognitive approaches are based on the premise that (a) psychological disorders are characterized by dysfunctional thinking based on dysfunctional beliefs, and that (b) improvement results from modifying dysfunctional thinking and beliefs (Beck, 1997). Cognitive theory can be used (a) separately from behaviorism, (b) as part of an integrated cognitive-behavioral practice, or (c) as *metatheory* for a general integrative approach (Alford & Beck, 1997).
- *Cognitive-behavioral approaches:* The mainstay of most contemporary practitioners, cognitive-behavioral approaches integrate both behavioral and cognitive techniques for changing problem thoughts, behaviors, and feelings. This chapter focuses on this commonly practiced combined approach. Several distinct forms of cognitive-behavioral approaches have been developed over the years:
  - *Multimodal therapy:* An approach that uses an eclectic set of interventions, Arnold Lazarus's multimodal therapy is based on assessment of the BASIC-ID: behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drug treatment.
  - *Rational emotive behavior therapy:* Developed by Albert Ellis, counselors in rational emotive behavior therapy (REBT) use *A-B-C* analysis to help clients identify the *belief* (B) that results in symptomatic *consequences* (C) in response to *activating* (A) *events*. This approach uses a confrontational style to dispute irrational beliefs.
  - *Reality therapy:* More philosophical than other cognitive-behavioral approaches, William Glasser's (1975, 1984) reality theory is based on the premise that people are driven by five basic needs—survival, love, power, freedom, and fun—and emphasizes how people *choose everything* they do, including feeling miserable.
  - *Mindfulness-based approaches:* The most recently developed, mindfulness-based approaches, such as mindfulness-based stress reduction and acceptance and commitment therapy, use observation of the mind and acceptance of thoughts and feelings to reduce anxiety, depression, addictive behaviors, and other symptoms. Because these put a paradoxical twist on traditional practices, they will be discussed in a separate section at the end of this chapter.

Cognitive-Behavioral Approaches

In a Nutshell: The Least You Need to Know

Cognitive-behavioral counselors have a no-nonsense, matter-of-fact approach to helping clients that is based on logic and education. Judith Beck (2005) wraps up cognitive approaches thusly: "In a nutshell, the *cognitive model* proposes that distorted or dysfunctional thinking (which influences the patient's mood and behavior) is common to all psychological disturbances. Realistic evaluation and modification of thinking procedures produces an improvement in mood and behavior" (p. 1; emphasis in the original; also, I did not pay her to mention nutshells). More simply stated, cognitive counselors believe unhelpful thoughts are the source of emotional and behavioral problems. Behavioralists add that maladaptive behavioral reinforcement also results in problem symptoms.

Cognitive-behavioral counselors use behavioral and cognitive techniques to directly treat symptoms, either by creating new behavioral associations or by helping clients think and feel differently. More so than any other approach, they rely heavily on psychoeducation to help clients change their thinking and behavioral habits. The role of counselors is educational, using their expertise to help clients learn how to manage their thoughts, feelings, and emotions more effectively. Clients are actively engaged by performing homework tasks out of session. Unlike psychodynamic and humanistic approaches, the overarching goal is not personality change; instead, cognitive-behavioral counselors have the more modest goal of helping clients learn how to better manage troubling symptoms. Developed using the scientific method, cognitive behavioralists

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have a strong research tradition, generating a solid evidence base for its effectiveness with a wide range of clinical concerns.

The Juice: Significant Contributions to the Field

If you remember one thing from this chapter, it should be …

A-B-C Theory

Originally developed by Albert Ellis (1962, 1996) using Beck's (1976) cognitive theory, the A-B-C theory is the centerpiece of rational emotive behavioral therapy. This model highlights the essence of all cognitive approaches: our *thoughts about a situation*—not the situation itself—are the source of emotional and behavioral problems. When you truly and deeply understand the wisdom in this statement, your life will never be the same—and you will be in a much better position to help others. So, to help lock this into your mind, I am going to put it in another one of those boxes:

> Our *thoughts about a situation*—not the situation itself—are the source of emotional and behavioral problems.

If you still need convincing, ponder how certain prisoners of war respond to torture. They experience forms of suffering far greater than most counselors and their clients face in the 21st century, making common presenting problems, such as having a critical parent or breaking up with a boyfriend, hard to label as problems. For example, there are numerous Tibetan monks and nuns who were brutally tortured by the Chinese in the 1960s and 1970s and, when eventually released, did not report symptoms of trauma (Hayward & Varela, 1992). In fact, some described having compassion for those who tortured them *while being tortured*. Such responses defy Western psychological theories about trauma, until the mediating beliefs are considered: these Buddhist practitioners have a different set of beliefs about "human rights" and maintain religious beliefs that emphasize learning to develop compassion for one's enemies as part of their spiritual development. Their beliefs informed their unusual response. Similarly, Viktor Frankl, whom we learned about in Chapter 7, also noted that the attitude of prisoners in Nazi concentration camps dramatically affected their mental and physical survival, with those able to make meaning better able to survive the most horrifying of circumstances. These are extreme examples of how a person's thoughts shape emotional and behavioral responses to an event. The event itself is not the cause.

However, for most of us mere mortals, when we experience an adverse event, *it seems as though* it is clearly the cause of negative thoughts and feelings because the beliefs silently mediate the response in the background. Ultimately, cognitive behavioralists argue, it is the individual who is responsible for choosing thoughts and beliefs that result in healthy behaviors and positive emotions. Let's not kid ourselves: that is quite a challenge.

So, let's explore the other end of the spectrum and consider a mundane, nonclinical illustration. I feel hurt when you insult me, saying, "Your last example about the Tibetans and Nazis is moronic." Common sense (in Western cultures; after all, common sense is always culturally defined) would hold that feeling hurt after being insulted is "normal." However, that is not the cognitive-behavioral approach. Instead, the question would be, What belief do I hold that results in my feeling hurt? In this case, I would have to answer that on the basis of my culture, class, age, immigration status, and education, I believe that a person should not harshly criticize another even if there is disagreement; the person should find a more polite way to say it (i.e., "Your example did not convince me"), not say anything at all, or find an academic source to refute my claim. However, a cognitive behavioralist would be quick to point out that my feeling hurt is the result of my beliefs, not your comment. To further complicate matters, another person with slightly different but similar beliefs may feel angry, ashamed, or embarrassed. How one feels is a result of their belief, not the comment. The comment is only the trigger.

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Cultural Considerations At this point, you may be wondering when is a comment fairly labeled an "insult," "rude," or "appropriate." The general answer is that it depends on a complex matrix of age, social class, gender, education, ethnicity, ability, and sexual orientation as well as the level of intimacy of the persons involved. The cognitive behavioralist would add that a person should opt to not blindly follow a belief that doesn't work for them (Ellis, 1994). Thus, even if a person comes from a cultural context in which insults are considered rude and reason to be hurt or angry, that person should consider adopting new beliefs that do not result in negative emotions. From this perspective, although culture influences our every thought, action, and feeling, each person still has choice in terms of *how*. It should be noted that this highly individualistic belief is not shared in all cultures, and counselors must consider this when working with diverse clients (see "Snapshot: Working With Diverse Populations"). Perhaps now you have a better sense of why cross-cultural communication becomes tricky quickly.

Clinical Applications Finally, let's also consider the types of beliefs you are likely to work with in session, beliefs that fuel depression, anxiety, substance abuse, eating disorders, and so on. The basic rule still applies: beliefs are the missing link between a situation and the resulting feelings and behaviors. For example, many people experience the feelings and behaviors that characterize depression, such as feeling sad, avoiding once-pleasurable activities, and difficulty getting out of bed in the morning. Many beliefs can fuel these feelings, such as "I am worthless," "No one cares about me," or "I will never achieve my dreams" (note: You will read about Beck's and Ellis's specific cognitive theories on depression in "The Viewing: Case Conceptualization" section). The counselor's job is to help clients realize that it was not the specific event, such as losing a job or girlfriend, that caused these feelings; instead, it is the belief clients have about these events that are causing the symptoms (e.g., "without that job or girlfriend, I am worthless").

Ellis developed the A-B-C model to illustrate how humans create their difficulties by the beliefs they hold. In this model, A is the "activating event" (the problem person, situation, etc.), B is the "belief" about the meaning of that event (that one is generally not aware of until a counselor points it out), and C is the emotional or behavioral "consequence" based on the belief (the symptoms).

Most clients come in able to see only the connection between A and C and thus report that A *causes* C: "I am depressed *because* my boyfriend broke up with me" or "I am angry *because* my boss favors my coworker." The counselor's job is to help the client identify the belief (B) that the client does not put into the equation, such as "I am worthless if a man decides not to be with me" or "I need to be the best in the office." These *irrational beliefs* are identified in assessment and targeted for change in the intervention phase by disputing these beliefs and adopting more realistic ones. If you are wondering, identifying the dysfunctional beliefs is far easier than changing them, but it is the requisite first step.

A-B-C Model

A = Activating event	**B = Belief about A**	**C = Emotional & behavioral consequences**
(Trigger event or person)		(Symptoms)

Try It Yourself

Identify a recent stressful event, then apply A-B-C analysis, beginning with the Activating event; then identify the Consequences; and finally identify the underlying Belief. What alternative belief may be more accurate and/or more useful?

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Rumor Has It: The People and Their Stories

Foundational Researchers

Ivan Pavlov A Russian physiologist and pioneer in behavior studies, Ivan Pavlov (1932) first described what is now referred to as *classical conditioning*: the ability to elicit a response (salivating) by pairing a natural stimulus (food) with a neutral stimulus (a bell).

B. F. Skinner Building on Pavlov's work, Skinner identified the principles of operant conditioning, which are used to shape new behaviors using consequences and schedules of reinforcement.

Albert Bandura A leading social learning theorist who built on Pavlov's and Skinner's work, Albert Bandura studied how people learn vicariously by observing others, their behaviors, and the consequences of those behaviors. His early experiments examined how children learn aggressiveness by watching adults act aggressively, a process now well known as *role modeling*. He advocated using behavioral methods not to control people but rather to help them develop their capacities for self-direction, sharing values similar to humanists (Bandura, 1974, 1986).

John B. Watson Considered the grandfather of behaviorism, Watson believed that behavior should be the sole focus of psychology, arguing that since cognitions were outside the realm of observation, they were inappropriate for empirical study. Most important, he established a culture of scientific research for the study of human behavior.

Joseph Wolpe Born in South Africa, trained as a Freudian, and conducting much of his research in the United States, Wolpe developed *systematic desensitization*, which is used to treat phobias and other anxiety disorders, after he found that traditional psychoanalytic approaches produced less-than-satisfactory results in treating posttraumatic stress in war veterans.

Leading Theorists and Practitioners

Aaron Beck One of the most disciplined researchers in the field of counseling and psychotherapy, Aaron Beck began his career attempting to scientifically validate Freud's theory of depression. When that failed, he began researching a cognitive model of depression (Beck, 1972, 1991) that resulted in his rejection and isolation from the psychiatric community for many years. Examining the underlying dysfunctional beliefs of psychopathology, Beck's (1988, 1991) research on depression, anxiety, substance abuse, eating disorders, relationship, and personality disorders are considered some of the most significant in the field.

Albert Ellis A flamboyant, humorous, and often abrasive figure, Albert Ellis first articulated his highly influential REBT based on the A-B-C theory of change in 1955. He continued to developing his ideas, teaching, and writing until his death in 2007 at the age of 93. His theory used cognitive, behavioral, and affective techniques to help people make themselves less miserable.

Arnold Lazarus Grounding his work in cognitive and social learning theories, Lazarus developed *multimodal therapy*, which involves a multifaceted assessment and encourages technical eclecticism to effect change across all areas of functioning and experience.

Donald Meichenbaum Donald Meichenbaum's cognitive-behavioral modification approach focuses on changing clients' self-talk, intervening to help clients interrupt their negative internal scripts and replace these with more realistic thoughts. Meichenbaum (1997) is one of the few cognitive behavioralists who grounds his work in postmodern assumptions that people construct their realities through language, informing a greater "discovery orientation" than other cognitive behavioralists.

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Big Picture: Overview of Counseling Process

The cognitive-behavioral approach involves four basic phases or steps:

- *Step 1: Assessment:* Counseling begins by obtaining a detailed behavioral and/or cognitive assessment of *baseline functioning*, including frequency, duration, and context of problem behaviors and thoughts.
- *Step 2: Target behaviors/thoughts for change:* Cognitive-behavioral counselors identify specific behaviors and thoughts for intervention (e.g., rather than the general goal of "improve mood," the counselor would target "increasing engagement in pleasurable activities," "initiating social contact," etc.).
- *Step 3: Educate:* Counselors educate clients on their irrational thoughts and dysfunctional patterns, helping to motivate them to make changes.
- *Step 4: Replace and retrain:* Finally, specific interventions are designed to replace dysfunctional behaviors and thoughts with more productive ones. Once the presenting symptoms have dissipated, treatment is ended.

Making Connection: Counseling Relationship

Educator and Expert

"REBT has always been very forceful, confrontative, and opposed to namby-pamby methods of therapy. It has particularly encouraged therapists to take the risks of quickly showing clients how they defeat themselves, rather than taking a long time to get to this point and rather than allowing clients to be evasive and defensive" (Ellis, 2003, p. 232).

Although the affective quality of connection exhibited by cognitive-behavioral counselors varies greatly—from cool and detached to warm and friendly to forceful and confrontative (but never namby-pamby)—the primary role of the counselor is the same: to serve as an expert who *directs* and *educates* the client and family on how to better manage their problems (Ellis, 2003). Especially in the working phase of counseling, the counselor's primary role is to educate clients on better ways to think and behave. Some cognitive-behavioral counselors, such as Ellis and Glasser, conceive of their role primarily as educators and adopt a highly directive approach. Others, such as Aaron Beck (1976), Judith Beck (2005), and Arnold Lazarus (1981), advocate a much warmer approach that "educates" using questions in Socratic style, requiring clients to critically and logically analyze their situation, offering a gentler means of guidance.

Empathy in Cognitive-Behavioral Counseling

True to their research foundations, cognitive-behavioral counselors increasingly use empathy, warmth, and a nonjudgmental stance to build a counseling alliance based on research results that indicate that these counselor qualities predict positive outcomes (Meichenbaum, 1997; see also the section "Common Factors Research" in Chapter 1). However, *the reason a cognitive-behavioral counselor uses empathy is quite different from the reason a humanistic counselor uses empathy*. This is frequently misunderstood, so I am going to say it again in case your mind was wandering: *cognitive-behavioral counselors use empathy for entirely different reasons than humanistic counselors*. Cognitive-behavioral counselors use empathy to create *rapport*, which then allows them to get to the "real" interventions that will change a client's behaviors, thoughts, and emotions. In dramatic contrast, for an experiential counselor, empathy *is* the intervention: they maintain that empathy is a curative process in and of itself (Rogers, 1961). The cognitive-behavioral counselor who uses empathy should not be seen as "manipulative" because in most cases the idea is to make the client feel more comfortable with the process, not to trick him or her. They should also not be seen as "integrating" experiential concepts because they are not using an experiential concept in the way an experiential counselor would use it. Instead, they are *adapting* it to work within their philosophical assumptions about counseling and the change process.

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Contemporary Cognitive-Behavioral Alliance

Judith Beck (2005) describes five practices for fostering the counseling alliance that reflect more contemporary sensibilities:

1. *Actively collaborate with the patient:* Decisions about counseling should be jointly made with the client.
2. *Demonstrate empathy, caring, and understanding:* Expressing empathy helps clients trust the counselor.
3. *Adapt one's counseling style:* Interventions, self-disclosure, and directiveness should be adjusted for each client based on personality, presenting problem, and so on.
4. *Alleviate distress:* Demonstrating clinical effectiveness by helping clients solve problems and improving their moods enhances the counseling relationship.
5. *Elicit feedback at the end of the session:* By asking clients "how did it go?" at the end of each session, counselors can intervene early in cases of alliance rupture.

By building a collaborative and engaged alliance, counselors are more likely to be effective and work through possible dysfunctional beliefs the client may have about counseling or the counselor that interfere with the process, such as "My counselor doesn't understand me" or "This will never work."

Written Contracts

Cognitive-behavioral counselors are perhaps the most businesslike when it comes to a counseling relationship (Holtzworth-Munroe & Jacobson, 1991), at least in terms of how they write about it on paper. And they are actually the most likely to write about it on paper. They frequently use *written contracts* spelling out the goals and expectations to help structure the relationship and to increase motivation and dedication with clients. Putting the goals and agreement in writing and having clients sign that they agree can be a very motivating experience for clients, creating a sense of commitment to the process.

The Viewing: Case Conceptualization

Baseline Functioning

At the beginning of treatment, sometimes even before the first session, cognitive-behavioral counselors conduct a baseline assessment of functioning that provides a starting point for measuring change. They ask clients to log the (a) frequency, (b) duration, and (c) severity of specific behavioral symptoms, such as depression, anxiety, panic, anger, social withdrawal, or conflict. Counselors may also include in the log identifying *antecedent* events that may have triggered the symptoms. Although it may seem that relying on clients' verbal recall of their symptoms is sufficient, most always a baseline assessment provides more detailed and accurate information than recall alone. In the case study at the end of this chapter, an assessment of baseline functioning is used to assess Maria's bipolar episodes.

A baseline log may look like this:

Problem Behavior	When?	How Long?	How Severe?	Events Before?	Events After?
Binging and purging	Monday evening: 7:00 p.m.; after a stressful day	1 hour	7 (on a 1–10 scale)	No breakfast; did not sleep well night before; tension with boss	Surfed Internet to distract self
Binging and purging	Friday night: 1:00 a.m.; after date	2 hours	9+	Fight with boyfriend during date; felt fat when saw other girls at club	Slept in next day; called boyfriend to make up

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Cognitive-Behavioral Functional Analysis

Originally a purely behavioral assessment technique that was later adopted also for cognitions, *functional analysis* involves careful analysis of the antecedents and consequences of problem thoughts and behaviors in order to identify naturally occurring triggers, rewards, and punishments to clearly identify cause-and-effect patterns (Meichenbaum, 1977). Counselors use functional analysis to examine what a person was doing and thinking as well as what was going on in the environment *before*, *during*, and *after* an episode of the symptom. For example, if a person reports cutting to manage stress, the counselor would ask about what she was thinking and doing before the episode as well as ask about what was happening in her life at the time: the who, what, where, and when of her life. Similar questions are used to assess what she was feeling and thinking during and after cutting and what was going on in her life. The counselor does this with several episodes early in treatment to identify patterns of what triggers and what reinforces the cutting. Functional analysis makes it easy to design successful interventions that are likely to quickly modify the problem behavior and thoughts.

Questions for Cognitive-Behavioral Functional Analysis

- What were you doing before (during and after) the episode? Where were you? Who was around? What time of day?
- What were you thinking before (during and after) the episode? Describe your inner conversation—thought by thought.
- What was going on in your life at the time (during and after)? What were the normal activities? What were atypical stressors?
- Repeat the above sequence of questions for "during" and "after" the episode.

Schemas and Core Beliefs

The cognitive approach of Aaron Beck (1976, 1997) focused on identifying and changing *schemas* and *core beliefs* that fuel problems in clients' lives, such as the belief that one must be perfect or that life should be fair. As the foundation for *dysfunctional thinking*, dysfunctional schemas are the root source of psychopathology; for the gains in counseling to be long-term, the counseling process must modify core schemas, not just specific thoughts about a particular issue (Beck, 1997).

Schemas are the deepest of four levels in Beck's conceptualization of cognitions:

1. *Automatic thoughts:* These thoughts are "knee-jerk" reactions to distressing situations that run through a person's mind and that the person can generally identify, such as "If my friend does not return my call in 24 hours, she does not really like me."
2. *Intermediate beliefs:* Extreme or absolute rules that are more general and shape automatic thoughts, such as "Good friends always return calls quickly."
3. *Core beliefs:* Also global and absolute, core beliefs are about *ourselves*, such as "I am worthless." Beck identifies two general unifying principles or themes that underlie most core beliefs: (a) autonomy (beliefs about being effective and productive versus helpless) and (b) sociotropic (beliefs about being lovable or unlovable).
4. *Schemas:* The deepest level of the cognitive structure, schemas are cognitive frameworks in the mind, organizing and shaping thoughts, feelings, and behaviors. Developed in childhood and informed by numerous other factors, including family, culture, gender, religion, and occupation, schemas may lie dormant until triggered by a specific event, such as "I am utterly worthless if even my best friend won't take the time to call me; no one really cares about me at all; what is the point of even trying to have friends if they only call when it's convenient for *them*?" Once triggered, information tends to be filtered to support the premise of the schema,

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and valid evidence to the contrary is ignored; for example, even when the friend calls apologizing that she didn't call back sooner because she felt ill, this is seen only as an excuse and further confirmation of being unlovable.

Assessing and correctly identifying schemas takes more time than assessing automatic thoughts and intermediate beliefs and adds greater depth to the counseling process. In the case study at the end of this chapter, the counselor identifies the core beliefs and schemas that fuel Maria's periods of depression and irritation.

Distorted Cognitions

Changing schemas is the ultimate goal in Beck's (1997) cognitive approach. To achieve this end, counselors often begin by identifying common *distortions* in automatic thoughts and intermediate beliefs that can then be changed using thought records (see "The Doing: Interventions"). These include:

1. *Arbitrary inference:* A belief based on little evidence (e.g., assuming your partner is cheating on you because she does not answer the phone immediately).
2. *Selective abstraction:* Focusing on one detail while ignoring the context and other obvious details (e.g., believing your boss/supervisor/instructor thinks you are incompetent because he or she identified areas for improvement in addition to strengths).
3. *Overgeneralization:* Just like it sounds, generalizing one or two incidents to make a broad, sweeping judgment (e.g., believing that because your son listens to acid rock, he is not going to college and will end up on drugs).
4. *Magnification and minimization:* Going to either extreme of overemphasizing or underemphasizing based on the facts (e.g., ignoring two semesters of your child's poor grades is minimizing; hiring a tutor for one low test score is magnification).
5. *Personalization:* A particular form of arbitrary influence that is especially common in intimate relationships where external events are attributed to oneself (e.g., "My spouse has lost interest in me because she did not want to have sex tonight").
6. *Dichotomous thinking:* All-or-nothing thinking: always/never, success/failure, or good/bad (e.g., "If my husband isn't madly in love with me, then he really doesn't love me at all").
7. *Mislabeling:* Assigning a personality trait to someone based on a handful of incidents, often ignoring exceptions (e.g., saying one's husband is lazy because he does not help immediately on being asked).
8. *Mind reading:* A favorite in families and couple relationships, mind reading is believing you know what the other is thinking or will do without any supporting evidence, and it becomes a significant barrier to communication, especially when related to disagreements and hot topics, such as sex, religion, money, housework, and so on (e.g., before your spouse says a word, you are defending yourself).

In addition, Beck (1997) has identified dysfunctional schemas that are commonly associated with specific personality disorders:

- *Dependent:* "I am helpless."
- *Avoidant:* "I might get hurt."
- *Passive-aggressive:* "I might get stepped on."
- *Paranoid:* "People are out to get me."
- *Narcissistic:* "I am special."
- *Histrionic:* "I need to impress others."
- *Compulsive:* "Errors are bad."
- *Antisocial:* "People are there to be taken."
- *Schizoid:* "I need plenty of space."

Irrational Beliefs: The Three Basic Musts

Similar to assessing schemas in Beck's cognitive approach, Ellis (1994, 2003) assesses for *irrational beliefs*, which are typically flagged by words such as "should," "ought," and

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"must." These are preferences that get exaggerated into absolutist, extreme thinking, and unrealistic beliefs that lead to depression, anxiety, and a host of other unpleasant experiences. Over the years, Ellis (2003) has collapsed what were originally 11 categories into three basic categories of irrational beliefs:

1. *Perfection-based worth:* "'I must be thoroughly competent, adequate, achieving, and lovable at all times, or else I am an incompetent worthless person.' This belief usually leads to feelings of anxiety, panic, depression, despair, and worthlessness" (p. 236).
2. *Justice for me:* "'Other significant people in my life, must treat me kindly and fairly at all times, or else I can't stand it, and they are bad, rotten, and evil persons who should be severely blamed, damned, and vindictively punished for their horrible treatment of me.' This leads to feelings of anger, rage, fury, and vindictiveness and to actions like feuds, wars, fights, genocide, and ultimately, an atomic holocaust" (pp. 236–237).
3. *Effortless perfection:* "'Things and conditions absolutely must be the way I want them to be and must never be too difficult or frustrating. Otherwise, life is awful, terrible, horrible, catastrophic and unbearable.' This leads to low-frustration tolerance, self-pity, anger, depression, and to behaviors such as procrastination, avoidance, and inaction" (p. 237).

Negative Cognitive Triad

Beck's (1972, 1976) theory of depression describes a *negative cognitive triad* that characterizes depressed thinking. This triad consists of three sets of negative thoughts that characterize the thinking of the person who is depressed:

1. Negative thoughts about the self (e.g., "I am worthless")
2. Negative thoughts about the world/environment (e.g., "life is unfair")
3. Negative thoughts about the future (e.g., "things will never get better")

Typically, people who are clinically depressed report having negative thoughts in all three areas rather than just one or two. For example, pessimism is defined by negative thoughts about the future but does not automatically lead to depression unless the person also has negative thoughts about the self and the world.

BASIC-ID

Designed to be a brief, solution-oriented, yet comprehensive approach, Lazarus's (1981) *multimodal therapy* is "best described as *systematic eclecticism*" (p. 4) and is organized around the seven-pronged assessment of the BASIC-ID: behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biology. The BASIC-ID questions can be used for a general global assessment or for a specific problem or symptom (p. 17).

BASIC-ID Assessment for General Mental Health

- *Behavior:* What behaviors are getting in the way of your happiness? What behaviors do you want to stop or start doing and/or do more of?
- *Affect:* What makes you laugh? Cry? What makes you mad, sad, glad, scared? Are you troubled by any particular emotions?
- *Sensation:* What do you especially like/dislike to see, hear, taste, touch, and smell? Do you experience frequent unpleasant sensations (such as pain, dizziness, tremors, etc.)? What are some sensual and sexual turn-ons and turn-offs for you?
- *Imagery:* What do you picture yourself doing in the immediate future? How would you describe your self-image? Body image? What do you like/dislike about these images? How do they influence your life?

(*continued*)

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- *Cognition:* What are some of your most cherished beliefs and values? What are your main "shoulds," "oughts," and "musts"? What are your intellectual interests and pursuits? How do your thoughts affect your emotions?
- *Interpersonal relationships:* Who are the most important people in your life? What do they expect from you and you of them? How do they affect you and you affect them?
- *Drugs and biology:* Do you have any medical concerns? What are your diet and exercise habits? What type of medications do you use? Do you drink, smoke, or use recreational drugs? How much, how often?

BASIC-ID can also be used to assess a specific area or problem:

- *Behavior:* What are you doing in relation to the problems? (e.g., frequent crying, insomnia, bathing less often)
- *Affect:* What are your problematic emotional states? (e.g., depressed mood, no enthusiasm for or interest in favorite activities, worry)
- *Sensation:* What physiological sensations are you experiencing in relation to the problem? (tight back and jaw; abdominal discomforts, exhaustion, tightness in chest)
- *Imagery:* What images or metaphors do you associate with the problem? (e.g., nightmares of being chased, daydreams of quitting job)
- *Cognition:* What thoughts and beliefs are associated with the problem? (e.g., catastrophic thinking, self-blame, perfectionistic thinking)
- *Interpersonal relationships:* Which of your relationships impact and are affected by the problem? (e.g., shutting out boyfriend, drifting away from friends, avoiding family)
- *Drugs and biology:* What medications and physical conditions impact and are affected by the problem? (e.g., gaining weight, on antidepressants for two months, minimal progress)

A client-focused approach, multimodal assessment is used to fit the treatment to the client rather than requiring that the client adapt to the treatment (Lazarus, 1981). Lazarus tailors treatment by *tracking* the clients' modality *firing order* or preferences and then sequences techniques accordingly. For example, if a client primarily describes the problem in behavioral terms, behavioral interventions will be the first line of intervention; then, if imagery were the second-most salient, it would be targeted next, and so forth. To keep treatment brief, Lazarus (1997) recommends using one of six modalities (B, S, I, C, I, D; basically, any modality *except* affect) to treat an issue "because affect cannot be directly modified but has to be accessed through one or more of the other six modalities" (p. 88). Lazarus contends that any shift in one area affects shifts in all the areas because they are interrelated.

DSM *Diagnosis*

Of all the mental health treatment approaches, cognitive-behavioral counseling is most closely aligned with the medical model, and thus they typically organize treatment using the diagnoses outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychological Association, 2013). Beck (1997) developed specific cognitive approaches for working with different diagnoses, such as depression, anxiety, eating disorders, substance abuse, and so on, having identified common dysfunctional cognitive patterns associated with each. Similarly, specific behavioral approaches have been developed for phobias, panic, depression, and various anxiety issues. Glasser (2003) is a notable exception, arguing that mental health symptoms are not "diseases" per se and that they can be changed when clients are supported in making new choices.

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Targeting Change: Goal Setting

"When people accept the fact that they largely control their own emotional and behavioral destiny, and that they can make themselves undisturbed or less disturbed mainly by acquiring realistic and sensible attitudes about the undesirable things that occur or that they make occur in their lives, they then usually have the ability and power of changing their belief system, making it more functional, and helping themselves to feel and to behave in a significantly less disturbed fashion" (Ellis, 2003, p. 220).

Symptom and Problem Resolution

Unlike depth psychology and humanistic approaches, cognitive-behavioral counselors' primary goal is to reduce presenting symptoms and problems. Symptom resolution is considered a sufficient goal in and of itself, and broader, growth-oriented goals are not considered necessary. Furthermore, cognitive-behavioral counselors do not have a laundry list of "normal" thoughts and behaviors that all clients should exhibit to be considered healthy; instead, they work with clients to identify which beliefs and actions are resulting in problems and change *those and only those*, not adding other long-term goals based on a theory of personality or health.

Independent Problem Solvers

The long-term vision in cognitive-behavioral approaches is to enable clients to independently solve their own problems by recognizing dysfunctional thoughts and behaviors early enough to keep them from creating unnecessary emotional distress (Beck, 1997; Ellis, 2003). This goal is conceptually quite different from psychodynamic and humanistic goals that target personality change. Aspiring to be realistic, cognitive-behavioral counselors do not promise dramatic changes in the structure of the psyche, but rather, they measure success by a client's ability to handle life stressors better, not perfectly. They also do not expect that life will be without future challenges and instead see the goal as preparing clients to better manage these on their own.

Behavioral and Measurable Goals

Specific treatment goals are identified through the above assessment procedures. Goals are stated in *behavioral* and *measurable* terms, such as "reduce arguments to no more than one per month." Once clear goals are agreed on, counselors also obtain a commitment from the client to follow instructions and complete out-of-session assignments in order to achieve the agreed-on goals. This agreement is often written down in the form of a written counseling contract. Getting client "buy-in" to complete assignments, immediately upon setting goals, greatly increases the likelihood of client follow-through.

Examples of middle phase cognitive-behavioral goals include the following:

- Reduce episodes of cutting and self-harm
- Replace perfectionist beliefs about work performance
- Reduce generalizations and mind reading with partner

Examples of late phase cognitive-behavioral goals include the following:

- Increase engagement in enjoyable activities, hobbies, and relationships
- End the use of substances to manage difficult moods; manage moods using healthy coping skills
- Redefine "I must be perfect to be loved" schema to increase capacity for intimacy

The Doing: Interventions

Psychoeducation

A hallmark of cognitive-behavioral counseling, psychoeducation involves teaching clients psychological principles and using them to handle problems (Ellis & Dryden, 1997;

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Lazarus, 1981). Psychoeducation can be done in individual or group sessions. The content typically falls into four categories:

- *Problem oriented:* Information about the patient's diagnosis and/or situation, such as attention-deficit/hyperactivity disorder, schizophrenia, alcohol dependence, depression, and so on. Counselors use this type of education to motivate clients toward taking new action.
- *Change oriented:* Information about how to reduce problem symptoms, such as improve communication, reduce anger, decrease depression, and so on. Counselors use this type of education to help clients actively solve their problems. For such education to be successful, clients must be highly motivated, and counselors need to introduce the new behavior in small, practical steps using everyday language.
- *Bibliotherapy:* "Bibliotherapy" is a fancy term for assigning clients readings that will be (a) motivating and/or (b) instructional for dealing with their presenting problem. Typically, counselors assign cognitive-behavioral self-help books, such as *Feeling Good* (Burns, 1988) or *The Worry Cure* (Leahy, 2005), to reinforce what is learned in session, but fiction or professional literature may also be assigned.
- *Cinema therapy:* Similar to bibliotherapy, cinema therapy involves assigning clients to watch a movie that will speak to the problem issues (Berg-Cross, Jennings, & Baruch, 1990).

Tips for Effectively Providing Psychoeducation and Task Setting *(Yes, these are similar to those used by Adlerians in Chapter 5)*

- *Practice!* Yes, I'm serious. There aren't too many counseling skills I recommend that new counselors "practice" on family and friends, but psychoeducation is the major exception. Try explaining concepts and research outcomes to people who haven't read books like this one. Notice the types of questions they ask after you explain a concept. That will help you learn what you might be leaving out, what type of jargon needs defining, and what people actually find useful.
- *Ask first:* Perhaps the single greatest secret to making psychoeducation work is *timing*: providing information when the client is in a receptive state. How do you know when they are ready? Ask them, "Would you be open to learning more about X?" If you fail to ask, you may not find a receptive audience. Alternatively, master the REBT style of confrontation and forget about timing.
- *Keep it very, very brief:* During a 50-minute sessions, I recommend keeping total psychoeducation time to one to two minutes—that's the max—and I am not exaggerating. Any other brilliant information you have to share should be saved for the following week because most clients cannot meaningfully integrate and act on more than a single principle at once.
- *Make one point—and one point only:* Try to teach only one concept, point, or skill in a session. Anything else is too much to be *practically* useful (see Judith Beck's recommendations in the section "Thought Records").
- *Ensure understanding and acceptance:* After briefly providing information, *directly ask* if clients understand and if they believe it is useful and realistic for their life.
- *Apply it immediately:* After you provide information, immediately identify how it can be practically applied in the client's life to address a problem that occurred in the past week or upcoming week.
- *Develop step-by-step tasks:* After offering two minutes of psychoeducation, the following 48 minutes involve step-by-step instructions on how to apply the information to solve a current problem. Get specific: who does what, when, where, and how often, and any resistance or potential roadblocks.
- *Follow up on tasks:* The next time you meet, ask the client if he or she used the information to any extent. If not, why not? If so, what happened?

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Socratic Method and Guided Discovery

Using the *Socratic method*, sometimes referred to as *guided discovery* or *inductive reasoning*, to gently encourage clients to question their own beliefs, cognitive counselors use open-ended questions that help clients "discover" for themselves that their beliefs are either illogical (i.e., contrary to obvious evidence) or dysfunctional (i.e., not working for them; Beck, 2005). A less confrontational approach than other techniques, when questioning the validity of belief, counselors generally take a relatively neutral stance, allowing the client's own logic, evidence, and reason to do the majority of convincing. Although the term "change" is used to describe what happens, in actuality tightly held beliefs are slowly eroded over time by the client's questioning and requestioning their validity in different situations.

Questions for Evaluating the Validity of Beliefs

- What evidence do you have to support your belief? What evidence is there to the contrary? So, what might be a realistic middle ground?
- What does respected person X (Y and Z) say about your situation? How could they all be wrong?
- If your child [or another significant person] were to say the same thing, how would you respond?
- What is the realistic likelihood that things will really go that badly? What is a more realistic outcome?
- You bring up one possible reason for X. Have you considered another explanation? Perhaps …?
- How likely is it that person X's behavior was 100% directed at you? What else might have played a role in his or her behavior?

Thought Records

Cognitive counselors use thought records (Beck, 1995) to help clients learn how to better respond to automatic thoughts, the most readily accessible dysfunctional thoughts (see Schemas and Core Beliefs above). By completing thought records, clients can use Socratic questions to help them counter their own negative thinking and develop more adaptive responses. Thought records involve identifying:

- *The triggering situation:* Event that triggered negative emotions and physical reactions
- *The automatic thought and strength of belief in terms of a percentage*
- *The resulting negative emotions and percentage of severity*
- *An alternative adaptive response*: Alternative interpretation of the event
- *The alternative outcome:* How much does the client believe the alternative interpretation and how does it change things in terms of percentage of belief, intensity of emotion, and new action?

To generate an alternative adaptive response, Beck (1995) recommends having clients ask themselves all of the following questions:

- What is the evidence that the automatic thought is true? Not true?
- Is there an alternative explanation for the situation?
- What's the worst that could happen? Could I live through it? What's the best that could happen? What's the most realistic outcome?
- What's the effect of my believing the automatic thought? What could be the effect of my changing my thinking?
- What should I do about it?
- If _____was in the situation and had this thought, what would I tell him/her? (or what would he/she do; p. 126)

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One of the keys to the technique is to use *percentage* to measure *how much a person believes* an automatic thought and *how strong the emotions are*. By using percentage of emotion and belief, clients can begin to see how dysfunctional beliefs wax and wane and that not all negative emotions are as devastating as others. Simply noting the variability in symptom severity generates hope, greater sense of control, and motivation to change; "third-wave" behavioralists using mindfulness and solution-focused counselors also focus on using these small indicators of control, change, and improvement to effect change.

Sample Thought Record

Trigger Situation: In department meeting boss praised Greg endlessly.

Automatic Thought with Strength of Thought in Percentage
- Thought 1: My boss likes Greg better than me: 90%
- Thought 2: I will never get anywhere in this company: 80%
- Thought 3: I am a loser: 70%.

Emotions with Strength of Emotion in Percentage
- Anger (at boss): 75%
- Helpless: 100%
- Hopeless: 80%

Adaptive Response
- Greg works harder and builds relationships better; I could do the same; I am a loser only if I don't give my personal best: 80%

Outcome
- Changes to belief in thoughts 1, 2, and 3: 20%; 30%; 20%
- Changes to emotions:
  - Angry (at self) 50%
  - Helpless 20%
  - Hopeless 10%
  - Motivated 50%
- Changes in behavior: Get to work earlier; goof off less; talk with boss

The most important role is for counselors to *motivate* clients to use these outside of session instead of falling back into old patterns. Judith Beck (1995, p. 127) recommends the following to ensure success with this relatively involved homework task:

- Counselors need to develop competence using thought records *personally* before asking clients to do so.
- Before introducing the thought record, the counselors should determine if the client understands and responds well to the basic principles of the cognitive model.
- Before introducing the thought record, clients should (a) demonstrate an ability to readily identify automatic thoughts and (b) have had a positive experience with *successfully reducing negative emotions* using a *verbal* variation of this intervention or Socratic questioning.
- The counselor should introduce thought records in two stages: first describing how to identify the automatic thought in one session and then, in the second session, how to generate adaptive responses.
- Clients should successfully identify automatic thoughts in several situations before moving on to identifying adaptive responses.
- If the client fails to complete thought records once properly introduced, the counselor should explore automatic thoughts related to doing the homework, such as believing that "these will not make a difference" or that "I don't have time in my busy schedule."

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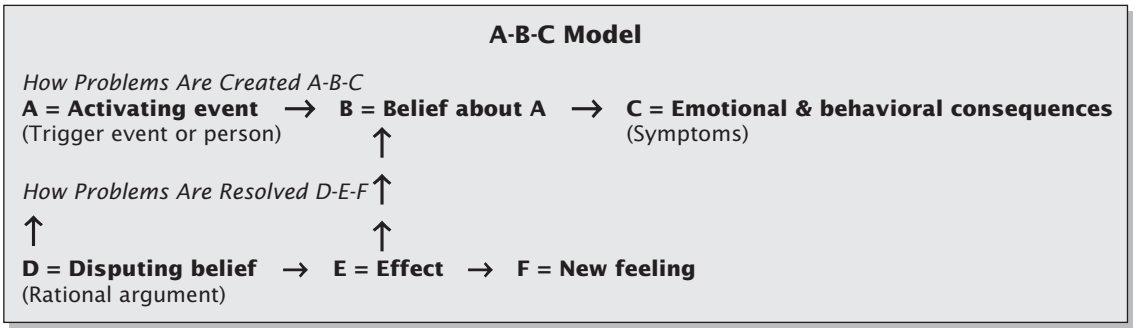
Disputing Beliefs and the REBT Self-Help Form

Ellis's A-B-C theory has a second part: you guessed it, D-E-F, which describes the interventions for *disputing* (D) irrational beliefs and the new *effects* (E) and *feelings* (F) (see "The Juice" for A-B-C; Ellis, 1994, 2004; Ellis & Dryden, 1997). The D-E-F intervention is used both in and out of session to help clients dispute troubling beliefs and replace them with new ones. Not attacking any or all beliefs, cognitive-behavioral counselors specifically target "hot" beliefs, the ones that are the most emotionally charged, rather than "warm" or "cool" beliefs that tend to cause fewer problems (Ellis, 2003).



Counselors use the A-B-C-D-E-F model to provide clients a means to analyze their own cognitions and behaviors and develop more adaptive responses. Before assigning this as homework, counselors usually practice in session on a whiteboard to demonstrate the process. Clients are then asked to do the exercises on their own during the week as distressing events arise. Over the years, several REBT self-help forms have been available (Ellis, 1997), the most recent of which is an interactive online version available from the Rational Emotive Therapy Network website (Ross, 2006). The REBT self-help form walks clients through the A–E process. In the case study at the end of this chapter, the counselor uses the REBT self-help form to help Maria dispute irrational beliefs about how she interprets the comments and actions of others.

Step 1: **Identify "A," the Activating or Trigger Event**

What situation are you upset about?

Example: My girlfriend cheated on me.

Step 2: **Identify "C," Unhealthy Negative Emotional and Behavioral Consequences**

What negative feelings and behaviors are you experiencing in response to this event?

Unhealthy Emotions	*Unhealthy Behaviors*
Example: I feel hurt, angry, vengeful, depressed, jealous, and plain sad.	Example: I yelled at her; broke up with her; can't sleep or eat; don't want to see anyone.

Step 3: **Identify "B," Irrational Beliefs**

What beliefs do you have that lead you to interpret the event so that you feel and behave they way you do? Include unrealistic demands, awfulizing, low frustration tolerance, people rating, and overgeneralizing (one or more) beliefs as well as demanding (a) to be approved of and feel self-worth, (b) to be treated fairly, and (c) for life to be effortless.

Example: Demands: I must be with Yvonne; she should not have done this; I can't live without her.

Awfulizing: This is the worst thing in the world that has ever happened to me; my life is over.

(*continued*)

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Low frustration tolerance: I can't stand being treated like this.

People rating: Her actions prove I am worthless. She is a terrible person.

Overgeneralizing: I will never find anyone like her again.

Step 4: **Identify "D," Irrational Beliefs Using Disputing Questions**

Example: Demands: Why must I be with her? Why is she the only woman on the planet for me?

Awfulizing: Is this really the worst thing that could happen?

Low frustration tolerance: Where is it written that being cheated on should not happen to me?

People rating: How can something she did reflect on my self-worth? She made a bad decision, but does that make her a bad person?

Overgeneralizing: Do I want to find someone like her if she cheated on me?

Step 5: **Identify "E," Effective, Rational Beliefs**

Example: Demands: I want to be with her—or at least I did want to be with her. I would have preferred having her in my life if she could have been faithful.

Awfulizing: Although this hurts, there are many things far worse that could happen to me. This only feels like the worst thing in the world. This type of thing has happened to millions of others for centuries; they survived, and I shall too.

Low frustration tolerance: I don't want to handle this, but I know that I can.

People rating: Her actions do not reflect on my self-worth; only my actions do that. I admire many of her qualities, but obviously she has flaws when it comes to faithfulness.

Overgeneralizing: When I am ready, I will look for someone whom I love as much and who can be faithful to me.

Step 6: **Identify New "F," Feelings and Behaviors, Such as "Healthy Negative Emotions" and Self-Helping Behaviors**

Healthy Negative Emotions	*Healthy Self-Helping Behaviors*
Example: I am very disappointed and hurt, but I will be okay.	Example: I will start hanging out with my best friend to cheer me up; I will talk with people I trust about this; when I am ready, I promise myself I will meet someone new.
It may take a while, but I will find someone else.	

Labeling Cognitions

In addition to Socratic questioning and direct confrontation, some clients find it helpful to identify and label distorted thinking to reduce its sway on them. Counselors can help them practice labeling distorted thinking in session so that clients can transfer this skill to their everyday lives. Most frequently, counselors use Beck's (1976) categories of distorted thinking described earlier in "The Viewing: Case Conceptualization" section:

- *Arbitrary inference:* "jumping to conclusions"
- *Selective abstraction:* "filtering out the positive"
- *Overgeneralization:* "making sweeping conclusions without evidence"
- *Magnification and minimization:* "emphasizing the negative and ignoring the positive"
- *Personalization:* "exaggerating one's responsibility" and/or "misinterpreting neutral comments"

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- *Dichotomous thinking:* "black-and-white thinking"
- *Mislabeling:* "attaching an extreme or overgeneralized label to a person or situation"
- *Mind reading:* "assuming negative thoughts and intentions on the part of other"
- *Catastrophizing:* "assuming the worst will happen"

Problem-Solving and Coping Skills Training

Meichenbaum (1977) noticed that while sometimes dysfunctional beliefs were the problem, at other times clients simply lacked problem-solving and coping skills. Thus, in addition to listening for the presence of erroneous beliefs, he listened for the "*absence* of specific, adaptive cognitive skills and responses" (p. 194). In the case of problem solving, the counselor engages in directly teaching clients how to (a) identify problems, (b) identify potential solutions, (c) select and act on a solution, and (d) evaluate the effectiveness of the solution. Similarly, with situations that are not easily solved, such as the loss of a loved one or a chronic condition, the counselor helps clients learn coping skills using a similar format: (a) identifying the specific elements where the client could cope better, (b) identify potential coping strategies, (c) choosing and applying these strategies, and (d) evaluating their effectiveness.

Changing Self-Talk: Stress Inoculation Training

As an alternative to and/or in addition to confronting irrational beliefs, clients can use *stress inoculation training* to help them change their negative *self-talk* and unhelpful inner dialogues and increase coping skills (Meichenbaum, 1977, 1985). Stress inoculation involves three phases:

1. *Education:* Providing information on negative self-talk and how it creates stress
2. *Training:* Rehearsing and practicing skills that apply to the client's situation
3. *Practice:* Applying skills in real-world situations

The process of stress inoculation training helps clients change their self-talk in all phases of experiencing stress: (a) preparing for a stressor, (b) confronting and handling the stressor, (c) coping with the feeling of being overwhelmed, and (d) reinforcing self-statements after stress. In the case study at the end of this chapter, the counselor uses stress inoculation training to help Maria change her habitual patterns of interpreting stressful interactions with others in the worst possible way.

Positive Self-Talk in Stress Inoculation Training (adapted from Meichenbaum, 1977, p. 155)

Things clients can tell themselves in each phase of coping with a stressor:

Preparing for a stressor

"I can develop a plan to deal with the stress."
"Just think about what I need to do rather than get anxious."
"Don't worry; worry won't help anything."

Confronting and handling the stressor

"One step at a time; I can handle this."
"Don't think about the fear: just think about what I have to do. Stay relevant. Just do it."
"This anxiety is what the counselor said I would feel; it's a reminder to use my coping skills."

Coping with the feeling of being overwhelmed

"Stay focused in the present. What is it that I have to do?"
"Don't try to eliminate the anxiety; just keep it manageable."
"When fear comes, just breathe."

(*continued*)

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Reinforcing self-statements

"You did it!"
"That wasn't as bad as I thought it would be."
"I am making good progress."

Cost-Benefit Analysis

Another common cognitive-behavioral technique, *cost-benefit analysis* helps confront dysfunctional thinking and create motivation by having clients identify the "costs" of a problematic behavior and the "benefit" (Ellis, 1991, 1994). Many problem behaviors develop by trying to avoid another problem, such as drinking to avoid feeling lonely. The counselor typically works with the client to make a written list of the costs and benefits or the pros and cons. The counselor has the client begin the list and then prompts the client to rationally think through the list from both perspectives.

Classical Conditioning: Pavlov's Dogs and Relaxation

Frequently used to treat anxiety disorders, classical conditioning was developed by Ivan Pavlov (1932) in his famous experiments with salivating dogs. In these experiments, he was able to train dogs to salivate at the sound of a bell by *pairing* the dog's natural response to salivate at the sight of food with a bell. When the bell was rung each time food was presented, the dog learned that the bell signaled that food was coming and began salivating. After enough repetition, the dog began to salivate with just the sound of the bell. This procedure is technically described in terms of *conditioned/unconditioned stimuli and responses*.

Initially, these responses were believed to be purely behavioral and almost involuntary, but later behavioralists found that thought and conscious learning were required even in this most basic form of conditions: "Contrary to popular belief, the fabled reflexive conditioning in humans is largely a myth. *Conditioning* is simply a descriptive term for learning through paired experiences, not an explanation of how the changes come about. Originally, conditioning was assumed to occur automatically. On closer examination it turned out to be cognitively mediated" (Bandura, 1974, p. 859); or, more to the point, "Humans do not simply respond to stimuli: they interpret them" (Bandura, 1977, p. 59). Classical conditioning is used in clinical settings to address phobias, child behaviors, and anxieties.

How Classical Conditioning Works

1. The Natural State of Affairs
Unconditioned Stimulus (UCS) → Unconditioned Response (UCR)

- Pavlov's Original Research: Dog Food → Salivation
- Treating Arachnophobia: Deep Breathing → Relaxation Response (slowed heart rate, decreased arousal)

2. Process of Pairing Conditional Stimulus with Response
UCS + Conditioned Stimulus (CS) → Conditioned Response (CR)

- Dog Food + Bell → Salivation
- Deep Breathing + Spider → Relaxation

3. Resulting Pairing
Conditioned Stimulus (CS) → Conditioned Response (CR)

- Bell → Salivation
- Spider → Relaxation

Operant Conditioning and Reinforcement Techniques: Skinner's Cats

Operant conditioning-based interventions use the principles identified by B. F. Skinner (1953, 1971) to modify human behavior, whether one's own or another's. The essential

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principle is to reward behavior *in the direction* of the desired behavior using small, incremental steps, a process called *shaping behavior*: "When a bit of behavior is followed by a certain kind of consequence, it is more likely to occur again, and a consequence having this effect is called a reinforcer" (Skinner, 1971, p. 27). Once a certain set of skills has been mastered, the bar is raised for which behavior will be reinforced, with ever-closer approximations to the desired behavior. Thus, if parents are trying to teach a child how to complete homework independently, they may begin by overseeing when, where, and how the child completes homework and reinforcing success and failure under these conditions. Once the child regularly succeeds with full oversight, the child is given an area of responsibility to master—perhaps when the homework is done—and reinforced for success in this area. Next, the child may be rewarded for managing the list of homework assignments without oversight. This process continues until the child completes homework independently, much to the parents' delight. Individual clients can apply operant conditioning to themselves to change habits, such as developing a new exercise regimen, lose weight, reduce anxiety, increase social activity, or any number of behavioral changes.

Forms of Reinforcement and Punishment In operant conditioning, desired behaviors can be positively or negatively reinforced or punished, depending on the desired behavior. The four options below are used alone or in combination to *shape* desired behavior.

Types of Reinforcement and Punishment

- *Positive reinforcement or reward:* Rewards desired behaviors by *giving* something desirable (e.g., a treat).
- *Negative reinforcement:* Rewards desired behaviors by *removing* something undesirable (e.g., relaxing curfew; take a day off from a routine task).
- *Positive punishment:* Reduces undesirable behavior by *adding* something undesirable (e.g., assigning extra chores; getting yourself to do a disliked task).
- *Negative punishment:* Reduces undesirable behavior by *removing* something desirable (e.g., grounding; denying self something enjoyable).

To boil it down even more:

	Increase Desired Behavior	Decrease Undesirable Behavior
Add Something	Positive reinforcement; reward	Positive punishment
Remove Something	Negative reinforcement	Negative punishment

Frequency of Reinforcement and Punishment The frequency of reinforcement and punishment is key to increasing or decreasing behavior:

- *Immediacy:* The more immediate the reinforcement/punishment, the quicker the learning, especially with young children.
- *Consistency:* The more consistent the reinforcement/punishment, the quicker the learning. Consistency involves rewarding or punishing a behavior *every time* it occurs or on a consistent schedule (e.g., every other time), creating predictability.
- *Intermittent reinforcement:* Random and unpredictable reinforcement *increases* the likelihood of a behavior, for better or worse. Thus, if a parent inconsistently reinforces curfew (sometimes enforces it and other times not), the child is *more likely* to break it. Based on the same principle, random positive reinforcement of well-established desired behaviors helps sustain them (e.g., randomly reinforcing positive grades with an extra privilege or treat).

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Point Charts and Token Economies Generally used with younger children but adaptable for adults, point charts (Patterson & Forgatch, 1995) or token economies (Falloon, 1991) are used to shape and reward positive behaviors by building up "points" that can be applied to privileges, treats, or purchases. The rewards must be motivating for the particular person involved; thus, what may work for one person may not work for another (Bandura, 1974). In addition, the rewards should follow the desired behavior closely in time and should be frequent enough for a person to feel motivated to do more. These principles can be used on children or adults to achieve behavioral change. For example, if parents want to increase a child's independence with homework, they can reward the child with a sticker that is placed on a chart; when the child accrues the target amount (perhaps five), the parents offer a motivating reward of some kind (e.g., a new book in a favorite series). Similarly, a typically shy adult wanting to increase his social connections could reward himself each time he contacts three friends in a week by buying a favorite CD or book.

Systematic Desensitization

A classic behavioral technique, *systematic desensitization* is a technique frequently used with anxieties and phobias wherein a client begins with a low-intensity image and increasingly works toward direct contact with the stressful stimulus (Wolpe, 1997). Using classical conditioning, desensitization is achieved by pairing relaxation with the stressful stimulus, first in small amounts and then slowly increasing exposure, a process called *reciprocal inhibition*. The underlying assumption is that a person cannot be both anxious and stressed at the same time.

The process involves (a) teaching relaxation techniques, (b) creating a hierarchy of anxiety triggers, and (c) working up the hierarchy until the client no longer experiences anxiety related to the trigger. For practical reasons (such as having to bring spiders and snakes to the office), imagery is used for most of the desensitization process. Adding a cognitive component to this classic behavioral technique, Meichenbaum (1997) found that adding a *coping image*—imagining oneself coping rather than mastering the anxiety-provoking situation—resulted in better and more sustainable outcomes. For example, if a man feared public speaking, a counselor would first teach him how to get into a relaxed state using breathing and visualization techniques. He would also work with the client to create a hierarchy of anxiety-provoking speaking events. Next, the counselor would have him get into the relaxed state and then *imagine* himself coping well with making a point during a business meeting; the client would practice doing this until he could imagine it without feeling anxious. The next step would be to have him identify a slightly more anxious situation—such as making a presentation at a meeting—and repeat the procedure. As the client gains confidence, this learning is transferred to real-world situations until the client is able to cope well with speaking in public.

In Vivo Exposure and Flooding

A variation on systematic desensitization, *in vivo exposure* and *flooding* are used to treat anxiety and phobias. In vivo exposure refers to putting the client in real-life (in vivo), anxiety-provoking situations while supporting clients as they face their fears (Spiegler & Guevremont, 2003). Often, a hierarchy similar to that used in systematic desensitization is used to expose the client in small doses to the feared situation or object, such as spiders or public speaking. In contrast, flooding refers to intense and prolonged exposure to the anxiety-provoking stimulus, either imagined or in vivo. In flooding, the client is not allowed to engage in the anxiety-reducing behaviors, and the fear generally resolves itself rapidly. Obviously, exposure treatments are appropriate for limited problems and are not appropriate for all clients, but when they are a good fit, they can be very effective in reducing phobias and anxiety.

Eye Movement Desensitization and Reprocessing

A highly specialized technique that requires additional training, eye movement desensitization and reprocessing (EMDR) is a form of exposure therapy used with trauma and stress.

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Although initially controversial, EMDR is recognized by the National Institute of Mental Health as a tier-1 intervention for trauma. The procedure involves having clients imagine the traumatic or anxiety-provoking event while using rapid eye movements to create bilateral stimulation of the brain (Shapiro, 2001). During the process, the counselor asks questions about the associated memories that surface. The eye movements are used to help reconnect memory networks with more adaptive semantic memory networks. The EMDR specialist identifies negative and positive cognitions to structure the treatment, using the eye movements to defuse the negative cognition and associated bodily sensations. As this wanes, the client is then asked to "install" new positive cognitions, again using eye movements to affect memory networks. The effectiveness of EMDR has been the subject of ongoing debate, with research and meta-analyses having mixed results (Nowill, 2010).

Putting It All Together: Cognitive-Behavioral Case Conceptualization and Treatment Plan Templates

Theory-Specific Case Conceptualization: Cognitive-Behavioral

Use the prompts below to develop a theory-specific case conceptualization; the case study at the end of the chapter provides an example.

- **Baseline Assessment of Symptomatic Behavior:** Provide a baseline assessment of the symptomatic behavior:
- *Symptom:* Define behaviorally; also include the following
  - Frequency
  - Duration
  - Context(s)
  - Events before
  - Events after

A-B-C Analysis of Irrational Beliefs: Describe the activating events, consequences, and mediating beliefs related to the problem (or particular incident):

- Activating event ("problem"): ___
- Consequence (mood, behavior, etc.): ___
- Mediating beliefs (unhelpful beliefs about event that result in C):

Schema and Core Beliefs: Describe three to five problematic schemas and core beliefs that relate to the presenting problem(s), which may include:

- Arbitrary inference
- Selective abstraction
- Overgeneralization
- Magnification/minimization
- Personalization
- Absolutist/dichotomous thinking
- Mislabeling
- Mind reading

BASIC-ID: Assess the client in all areas:

- Behavior
- Affect
- Sensation
- Imagery
- Cognition
- Interpersonal relationships
- Drugs and biology

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Treatment Plan Template: Cognitive-Behavioral

Use this treatment plan template for developing a plan for clients with depressive, anxious, or compulsive types of presenting problems. Depending on the specific client, presenting problem, and clinical context, the goals and interventions in this template may need to be modified only slightly or significantly; you are encouraged to significantly revise the plan as needed. For the plan to be useful, goals and techniques should be written to target specific beliefs, behaviors, and emotions that the client is experiencing. The more specific, the more useful it will be to you.

Treatment Plan

Initial Phase of Treatment

Initial Phase Therapeutic Tasks

1. *Develop working counseling relationship. Diversity consideration:* [Describe how you will adapt use of warmth, "expertise," and emotional versus rational focus based on ethnicity, gender, age, and so on.]
   Relationship building intervention:
   a. Use warmth and **empathy** to build rapport; establish **credibility**.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* [Describe here how you will specifically adjust assessment based on cultural, socioeconomic, sexual orientation, gender, and other relevant norms; Consider whether traditional individualistic goals are appropriate for client's background.]
   Assessment Strategies:
   a. Obtain **baseline** of problem behavior; **functional analysis** of problem behaviors and thoughts; *DSM* diagnosis.
   b. Identify specific **schemas** and **irrational beliefs** related to presenting problem.

Initial Phase Client Goals *(One to Two Goals):* Manage crisis issues and/or reduce most distressing symptoms

1. *Decrease* [name specific crisis-related behavior] to reduce [crisis] symptoms.
   Interventions:
   a. Use **functional analysis** to identify one behavior the client is willing to do to reduce severity of symptoms.
   b. Use **control theory** to motivate client to *choose* functional behaviors that move toward desired life goals.

Working Phase of Treatment

Working Phase Counseling Tasks

1. *Monitor quality of the working alliance. Diversity consideration:* [Describe how you monitor the client's ongoing sense of connection with counselor and how you will specifically adapt monitoring and/or relationship based on client age, gender, cultural, sexual orientation, socioeconomic status, etc.].
   Assessment Intervention:
   a. Use Session Rating Scale; verbally ask clients if sessions are beneficial and if they feel understood by counselor.

Working Phase Client Goals

1. *Decrease* [specify: **distorted cognitions**; e.g., overgeneralizing] and [specify: irrational beliefs; e.g., "I must be loved at all times"] to reduce depression/anxiety and so on.

(*continued*)

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Interventions:
a. **Disputing** irrational beliefs in session and using **REBT self-help form.**
b. **Socratic questioning** related to depressive (anxious) beliefs.
c. **Label dysfunctional** cognitions to counter automatic thoughts.

2. *Increase* [specify: **functional behaviors**] and choices to reduce depression and anxiety.
Interventions:
a. Use **operant conditioning** and **in vivo exposure** to develop positive behavioral choices.
b. Use **choice theory** and **cost-benefit analysis** to motivate clients to make positive behavioral choices.

3. Increase positive **self-talk** related to [specify: presenting problem] to reduce feelings of hopelessness, anxiety, fear, and so on.
Interventions:
a. **Stress inoculation training** and **problem-solving training** related to presenting problem.
b. Use **thought records** to develop alternative thoughts related to presenting problem.

Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity consideration:* [Describe how you will access resources in the communities of which they are a part to support them after treatment ends.]
Intervention:
a. Use thought records and REBT self-help form for potential future problems.

Closing Phase Client Goals

1. *Increase* **positive self-talk** about self-worth and expectations from life to reduce feelings of hopelessness, anxiety, fear, and so on.
Interventions:
a. **Socratic dialogue** to help client develop positive views of self and life.
b. Use **thought records** to develop realistic self-talk about personal worth.

2. *Decrease* **dysfunctional schemas** and **core beliefs** about self, others, and life to reduce depressive, anxious, and compulsive symptoms.
Interventions:
a. Dispute three basic "musts," negative cognitive triad, and related core schemas.
b. **Thought records** to develop alternative, realistic schema, and core beliefs above worth as person and relationships.

Reality Theory

In a Nutshell: The Least You Need to Know

Arguably the original "get-real" counseling approach, reality theory counseling is an active approach that incorporates many elements of behavioral and cognitive approaches but is based on a different model of human motivation. Developed by William Glasser, who was dissatisfied with the outcomes of psychoanalytic therapy when working in a girls' prison, reality theory is based on *choice theory*, which posits that the choices people make determine the quality of their lives and are the means for both creating and resolving problems. In a matter-of-fact manner, reality counselors simply allow reality to confront clients and help them identify what needs to

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change: "Is what you're doing getting you what you want?" The counselor then helps clients identify alternative choices and behaviors that are more likely to get them what they really need.

Choice Theory

Developed from his early *control theory*, which conceptualized people as driven by inner control systems, Glasser's (1975, 1997, 1998, 2000) *choice theory* posits that the choices people make determine the quality of their lives. Glasser believed that five basic needs motivated the choices people make:

- Belonging/relationships
- Power/achievement
- Fun
- Freedom/independence
- Survival

The choices people make inform their behaviors, which Glasser conceptualized as *total behavior*, which incorporates acting, thinking, feeling, and physiology. Using the metaphor of four car wheels, any one behavior is inherently connected to all other elements. For example, a person cannot decide to get drunk (or stay sober) without the choice impacting thoughts, feelings, and physiology.

Similar to behavioralists and solution-focused counselors (see Chapter 12), Glasser believed that when a person wants to change, *action* is generally the easiest and most effective place to start. Thus, when assessing clients, counselors use choice theory to identify the actions clients choose that drive the negative thoughts, feelings, and physical symptoms (e.g., nagging a partner or not giving one's best at the office) and target these for later intervention. In the case study at the end of this chapter, the counselor uses choice theory to help Maria make better choices about how she uses her time and interacts with others.

Reality Theory Behavioral Analysis

In reality therapy, counselors analyze behavior to help motivate clients to take responsibility for the quality of their lives and make choices to improve their situations using the WDEP (Wants-Doing-Evaluation-Planning) system (Glasser, 2000; Wubbolding, 2008).

W = Exploring Wants, Needs, and Motivations

Counselors explore clients' wants using a series of questions to assess what clients really want and need in all areas of their lives: family, friends, job, self, health, and so on (Wubbolding, 2008):

- What do you want that you *are* getting? What do you want that you *are not* getting? What are you getting that you don't want?
- What are you willing to settle for?
- How much effort are you willing to exert to get what you want? How committed are you?
- What do you have to give up to get what you want? Are you willing to do this?

Doing = Discussing What Clients Are Doing and the Resulting Direction

Compared to thoughts, feelings, and physiology, Glasser believed that behaviors were the easiest thing for people to control. Thus, he asked clients to examine their actions and if they were helping them move toward their wants and needs:

- What actions are you taking right now that are helping you fulfill your wants?
- What actions are taking *away from* your wants?
- When you are feeling bad [name the symptom], what actions do you take? What thoughts inform your choice to take this action?

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E = Evaluating the Effectiveness of Actions and Choices

Next, counselors encourage clients to *self-evaluate* the effectiveness of their actions and choices. Some ways counselors encourage this is to ask evaluative questions:

- Are these actions helpful or hurtful to you in the short run? Long run?
- Are these actions improving your relationships or destroying them?
- Are these actions your best effort or least effort?

P = Planning a Course of Action

Based on clients' evaluations of their actions, counselors help them develop a doable, realistic plan for getting more of what they want. They strive to keep plans simple and attainable with measurable goals that are within the client's control.

Mindfulness-Based Approaches

In a Nutshell: The Least You Need to Know

Described as the third wave of behavioral therapy (with "pure" behavioral therapy the first wave and cognitive-behavioral therapy the second), mindfulness-based approaches add a paradoxical twist to cognitive-behavioral approaches: *accepting* difficult thoughts and emotions in order to transform them (Hayes, 2004). Counselors using mindfulness-based approaches encourage clients to curiously and compassionately observe difficult thoughts and feelings *without the intention to change them.* By changing *how* clients relate to their problems—with curiosity and acceptance rather than avoidance—they experience new thoughts, emotions, and behaviors in relation to the problem and thus have many new options for coping and resolving issues. These practices require counselors to have their own mindfulness practice and training before trying to teach clients to do the same.

A Brief History of Mindfulness in Mental Health

Mindfulness has an unusual history as a cognitive-behavioral technique: it was not developed in a researcher's lab or from a Western philosophical tradition. Instead, mindfulness comes from religious and spiritual traditions, making it a surprising favorite for cognitive-behavioral counselors who ground themselves almost exclusively in Western scientific traditions. Most commonly associated with Buddhist forms of meditation, mindfulness is found in virtually all cultures and religious traditions, including Christian contemplative prayer (Keating, 2006), Jewish mysticism, and the Islamic-based Sufi tradition. Although it has religious roots, mindfulness entered mental health as a nonreligious "stress reduction" technique and was intentionally separated from religion and spiritual elements and adapted for use in behavioral health settings (Kabat-Zinn, 1990).

Over 30 years ago, Jon Kabat-Zinn (1990) began researching the mindfulness-based stress reduction (MBSR) program at the University of Massachusetts, which has been highly influential in making mindfulness a mainstream practice in behavioral medicine. The MBSR program is an eight-week group curriculum that teaches participants how to practice mindful breathing, mindful yoga postures, and mindful daily activities. Participants are encouraged to practice daily at home for 20 to 45 minutes per day. MBSR shows great promise as an effective treatment for a wide range of physical and mental health disorders, including chronic pain, fibromyalgia, psoriasis, depression, anxiety, attention-deficit/hyperactivity disorder, eating disorders, substance abuse, compulsive behaviors, and personality disorders (Baer, 2003). Closely related, Teasdale, Segal, and Williams (1995) have adapted the MBSR curriculum for depression relapse in their program, mindfulness-based cognitive therapy (MBCT). With 50% of "successfully" treated cases of depression ending in relapse within a year, MBCT counselors are using mindfulness to reduce the high relapse rate, with promising findings.

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In addition to including MBSR (Kabat-Zinn, 1990) and MBCT (Teasdale et al., 1995), mindfulness has been integrated into two counseling approaches that have also shown great promise in treating a wide range of clinical conditions: dialectic behavioral therapy (Linehan, 1993) and acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999).

Mindfulness Basics

The most common form of mindfulness involves observing the breath (or focusing on a repeated word, a *mantra*) while quieting the mind of inner chatter and thoughts (Kabat-Zinn, 1990). Focus is maintained on the breath, grounding the practitioner in the present moment *without judging* the experience as good or bad, preferred or not preferred. Usually within seconds, the mind loses focus and wanders off—thinking about the exercise, a fight that morning, to-do lists, past memories, or future plans; feeling an emotion or itch; or hearing a noise in the room. At some point, the practitioner realizes that the mind has wandered off and then returns to the object of focus without berating the self for "failing" to focus but rather with compassion understanding that the loss of focus is part of the process—refraining from beating oneself up is usually the most difficult part. This process of focusing, losing focus, regaining focus, losing focus, and regaining focus continues for an established period of time, usually 10 to 20 minutes.

Gehart and McCollum (2007, 2008; McCollum & Gehart, 2010) have used mindfulness to help first-year counselors and therapists learn how to develop therapeutic presence, with encouraging reports from trainees who say that they notice significant changes both in and out of the therapy session. Trainees report being better able to be emotionally present with clients, less anxious in session, and better able to respond in difficult moments. Most report that their overall level of stress noticeably decreases within two weeks of practicing five days per week for two to ten minutes; they also report better relationships and a greater sense of inner peace—not bad for a 10- to 50-minute-per-week investment. So you might want to give it a try.

Starting Your Personal Mindfulness Practice

1. *Find a regular time:* The most difficult part of doing mindfulness is finding time—two to ten minutes several days a week. My colleague Eric and I have our students do five days per week. It is best to "attach" mindfulness practice to some part of your regular routine, such as before or after breakfast, working out, brushing your teeth, seeing clients, coming home, or going to bed (if you are not too tired).
2. *Find a partner or group (optional):* If possible, find a partner or meditation group with whom you can practice on a regular basis. The camaraderie will help keep you motivated.
3. *Find a timer (highly advisable):* Using a timer helps structure the mindfulness session, and many find that it helps them focus better because they don't wonder if time is up. Most mobile phones have alarms and timers that work well; you can also purchase meditation apps with Tibetan chimes for iPhones and other smartphones. Digital egg timers work well too—avoid the ones that tick.
4. *Sit comfortably:* When you are ready, find a comfortable chair to sit in. Ideally, you should not rest your back against the chair; rather, sit toward the front so that your spine is erect. If this is too uncomfortable, sit normally with your spine straight—but not rigid.
5. *Breathe:* Set your timer for two minutes initially and watch yourself breathe while quieting the thoughts and any other discourse in your mind:
    - Don't try to change your breathing; just notice its qualities, not judging it as good or bad.

(*continued*)

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- Know that your mind will wander off numerous times to both inner and outer distractions. Each time it does, gently notice it without judging. Perhaps imagine it disappearing like a cloud drifting off or soap bubbles popping or say "ah, that too" and then gently return your focus to watching your breath.
- Accept your mind how it is each time you practice; some days it is easier to focus than others. The key is to practice acceptance of "what is" rather than fall into the common pattern of being frustrated with what is not happening.
- The goal is *not* to have extended periods without thinking but rather to practice nonjudgmental acceptance and cultivate a better sense of how the mind works.

6. *Notice:* When the bell rings, notice how you feel. The same, more relaxed, more stressed? Try only to notice, without judging. You may or may not feel much difference; the most helpful effects are cumulative rather than immediate. If you happen to notice that you wish to go on, go ahead and add a minute or two the next time you practice. Slowly, you will add minutes until you find a length of time that works well for you. Don't extend the time until you feel a desire to do so.
7. *Repeat:* Our students report the best outcomes with shorter regular practices rather than longer but infrequent practices. Thus, doing five two-minute practices is likely to produce better outcomes than one ten-minute session each week.

Try It Yourself

Use a timer to practice mindfulness for two to five minutes. Try to focus on your breath while quieting your thoughts. Afterwards, notice how you feel. What types of thoughts went through your head during this practice session?

Resources to Support Your Practice

- *Free meditation podcasts:* You can download free guided mindfulness meditations and other free resources to support your practice from my website (www.dianegehart.com) and from UCLA's Mindfulness Awareness Research Center (www.marc.ucla.edu).
- *Workbooks: The Mindfulness-Based Stress Reduction Workbook* (Stahl & Goldstein, 2010) and *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy* (Hayes & Smith, 2005) are excellent workbooks to teach you practical techniques.

Specific Mindfulness Approaches

MBSR and MBCT

Not primarily about becoming a good meditation practitioner, these mindfulness-based group treatments are designed to help clients change *how they relate to their thoughts and internal dialogue*. Using a highly structured group process, clients are introduced to mindfulness breathing (similar to the instructions discussed earlier) as well as mindful yoga (stretching) positions and mindful daily activities (e.g., washing dishes mindfully, walking; Kabat-Zinn, 1990). Depending on the group's focus, clients may be taught to apply mindfulness to physical conditions, difficult emotions, depressive thinking, and so on. The group format is ideal for motivating clients to practice regularly at home and report back to the group on their progress.

The eight groups in MBSR cover the following:

Session 1: Introduction to mindfulness: Foundations of mindfulness and body scan meditation
Session 2: Patience: Working with perceptions and dealing with the "wandering mind"
Session 3: Nonstriving: Introduction to breathing meditation; mindful lying yoga; qualities of attention

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Session 4: Nonjudging: Responding versus reacting; awareness in breath meditation; standing yoga; research on stress
Session 5: Acknowledgment: Group check-in on progress; sitting meditation
Session 6: Let it be: Skillful communication; loving-kindness meditation; walking meditation; daylong retreat
Session 7: Everyday mindfulness: Mindful movement and everyday applications; practicing on one's own life
Session 8: Practice never ends: Integrating with everyday life

The eight groups of MBCT cover the following (Segal, William, & Teasdale, 2002):

Session 1: Automatic pilot: Introduce mindfulness; eating mindfulness exercise; mindfulness body scan
Session 2: Dealing with barriers: Explore mental chatter using the body scan exercise
Session 3: Mindfulness of the breath: Introduce mindfulness breath focus and three-minute breathing space exercise
Session 4: Staying present: Link mindfulness to automatic thoughts and depression
Session 5: Allowing and letting be: Introduce acceptance and allowing things to just be
Session 6: Thoughts are not facts: Reframe thoughts as just thoughts and not facts
Session 7: How can I best take care of myself?: Introduce specific techniques for depressive thoughts
Session 8: Using what has been learned to deal with future moods: Motivate to continue practice.

Through these mindfulness exercises, clients learn to do the following:

- Deliberately direct their attention and thereby control their thoughts better
- Become curious, open, and accepting of their thoughts and feelings, even those that are unpleasant
- Develop greater acceptance of self, other, and things as they are
- Live in and experience themselves in the present moment

Dialectical Behavior Therapy

Originally developed for treating suicidal borderline clients, *dialectical behavior therapy* (DBT; Linehan, 1993) was one of the first mindfulness-informed therapies, incorporating both the concept of mindfulness and acceptance. As an evidenced-based cognitive-behavioral therapy, this approach is covered in extensive detail in Chapter 12.

Acceptance and Commitment Therapy

A behavioral approach that shares philosophical assumptions with postmodern, narrative, and feminist approaches (see Chapter 14), acceptance and commitment therapy (ACT, pronounced "act," not "A-C-T") is based on the postmodern premise that we construct our realities through language, which shapes our thoughts, feelings, and behaviors. ACT practitioners believe that human suffering is in large measure created and sustained through language: "It is not that people are thinking the wrong thing—the problem is thought itself and how the verbal community (contemporary culture) supports its excessive use as a mode of behavioral regulation" (Hayes et al., 1999, p. 49). Unlike traditional cognitive behavioralists, ACT practitioners assert that attempts to control thoughts and feelings and avoid direct experience are the *problem*, not the solution. Instead, they advocate mindfulness-based *experiencing* to promote acceptance of the full range of human emotions: "In the ACT approach, a goal of healthy living is not so much to feel *good*, but rather to *feel* good. It is psychologically healthy to feel bad feelings as well as good feelings" (Hayes et al., 1999, p. 77).

The same acronym, ACT, is used to outline the process of counseling:

A = Accept and embrace difficult thoughts and feelings
C = Choose and commit to a life direction that reflects who the client truly is
T = Take action steps toward this life direction

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The first phase in ACT is to accept and embrace the very thoughts and feelings clients have been trying to avoid via their symptoms: accepting loss, feeling fear, and acknowledging anger. Counselors caution clients to not "buy into" their thoughts and challenge them to see the flimsy link between reasons (i.e., excuses) and causes of their behavior. At the same time, they help clients develop a *willingness* to experience difficult thoughts and feelings with their *observing self*. Through this process of observation, clients are better able to identify their true values and selves, which helps them not only readily identify a life direction but also commit to pursuing it. As you might imagine, this is not as simple as it sounds. In the action phase, most clients reexperience the resistance to experience and the negative thoughts that brought them to counseling in the first place. However, with increased ability to accept these and a renewed commitment to pursue a meaningful life direction, the counselor can work with the client when obstacles arise in pursuing new action.

Tapestry Weaving: Working with Diverse Populations

Ethnic, Racial, and Cultural Diversity

Because cognitive-behavioral therapy (CBT) defines behavioral norms (e.g., each culture defines "rational" differently), therapists must carefully apply this approach with diverse populations to avoid conflicts in values and relational styles. CBT's emphasis on the expert stance in relation to clients has strengths and weaknesses when working with diverse populations. Men and certain culture groups, such as Latinos, Asians, and Native Americans, often prefer active, directive therapy (Gehart & Lyle, 2001; Pedersen, Draguns, Lonner, & Trimble, 2002). However, hierarchical difference may cause a rebellious reaction in some clients (e.g., highly educated adults or teens) or an overly compliant and withholding response in others (e.g., women who have a habit of people pleasing; Gehart & Lyle, 2001).

Because cognitive-behavioral approaches involve identifying "irrational beliefs" and "problematic behaviors," both of which are culturally and contextually determined, counselors must be particularly alert to unintentionally perpetuating dominant cultural norms with diverse clients. Counselors must carefully evaluate treatment goals prior to intervention to ensure that they do not clash with religious, cultural, racial, socioeconomic, or other values and realities, and to consider how the various cultures of which a client is a part may have conflicting values. To ensure cultural appropriateness of their methods, researchers have explored the specific effects of ethnicity in CBT practice, identifying in which contexts ethnicity plays the greatest role. For example, initial studies have found no significant difference when using CBT for depression with European Americans, Latinos, and Asian Americans (Marchand, Ng, Rohde, & Stice, 2010), yet another study found that ethnicity played a significant role in the strength of the therapeutic relationship over the course of therapy with perpetrators of domestic violence (Walling, Suvak, Howard, Taft, & Murphy, 2012); thus, ongoing research will further refine our understanding of how best to use CBT with diverse populations. Based on this emerging research and clinical expertise, CBT therapists have begun developing recommendations for specific ethnic groups.

Hispanic and Latinos

CBT is generally considered to be culturally consistent and appropriate for working with Hispanic and Latino clients (Organista & Muñoz, 1996). Therapists have developed several suggestions for successfully working with Hispanic and Latino clients using CBT.

- *Addressing language needs:* Language issues are central when working with many immigrant Latino families, who often prefer to discuss private and emotional issues in their native language (most people prefer to discuss emotional issues in their native language, and Spanish speakers are particularly passionate about this). In addition, Spanish-speaking therapists need to consider how to translate not just

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words but concepts across cultures; for example, in one CBT program for Latinos, the A-B-C method for disputing irrational beliefs was streamlined and translated as the *Si, Pero* (Yes, but…) technique (Piedra & Byoun, 2012).

- *Increasing experiential components:* When modifying standard CBT curricula, therapists often increase the applied and experiential components: rather than talk about it, do it (Piedra & Byoun, 2012).
- *Respecting cultural value of* familismo*:* Family is highly valued, with individual interests often placed second to family needs; thus, CBT therapists need to be careful to avoid labeling a Latino/a's choice to put family above personal needs as "irrational" (Duarté-Vélez, Bernal, & Bonilla, 2010; González-Prendes, Hindo, & Pardo, 2011).
- *Respecting cultural value of* personalism: Latino culture values warm and trusting personal relationships, which therapists need to integrate into the therapeutic relationship (González-Prendes, Hindo, & Pardo, 2011). To create a context of *personalism*, therapists can begin their initial session in "small talk" to share their background and learn about the client's (Organista & Muñoz, 1996).
- *Respecting the cultural value of* respecto: Latino families are typically hierarchical, with formal expectations of respect to parents and elders; in addition, clients may prefer to be addressed with formal titles, Señor or Señora (González-Prendes, Hindo, & Pardo, 2011; Organista & Muñoz, 1996).
- *Respecting the cultural value of* machismo: Often misunderstood in its negative extreme, within its native culture machismo refers to a man's sense of leadership, loyalty, and responsibility to provide and care for the family (Duarté-Vélez, Bernal, & Bonilla, 2010; González-Prendes, Hindo, & Pardo, 2011).
- *Working with spirituality:* Many Hispanic/Latino clients have a strong sense of spirituality, most often Roman Catholic (Duarté-Vélez, Bernal, & Bonilla, 2010). Prayer, church, and the church community are resources that therapists can tap into; but therapists should also discuss the use of prayer to ensure that it facilitates active problem solving rather than reduces the clients' sense of efficacy or responsibility (Organista & Muñoz, 1996).
- *Attitude to gay/lesbian relationships:* Often due to their strong religious beliefs, Hispanic families may have a highly negative response to a child's coming out, often viewing same-sex attraction as a "sin," creating significant cultural dissonance and rejection for gay Latino youth (Duarté-Vélez, Bernal, & Bonilla, 2010).
- *Addressing immigration, migration, and acculturation:* Many Hispanic clients have complex immigration and migration patterns, often moving back and forth between cultures multiple times and family members living in different countries at the same time. In addition, acculturation issues between parents and children are often something that CBT therapists need to help them address (Piedra & Byoun, 2012).

African Americans

Many also consider CBT an appropriate choice for working with African Americans because it helps them to directly dispute problematic social beliefs, and it focuses on present behaviors (Kelly, 2006; McNair, 1996). Recommendations for adaptation include:

- *Forming a collaborative relationship:* Clients should be invited to work with the therapist in setting goals, agreeing on time frames; this relationship should be used to foster a greater sense of self-efficacy in the client (Kelly, 2006; McNair, 1996).
- *Focusing on behaviors and skills:* Rather than analyzing the past, therapists should focus on problems that are experienced in the present and are of immediate importance and relevance to the client (McNair, 1996).
- *Empowerment:* CBT therapists can help empower clients by helping them develop coping and communication skills and expand their support networks (Kelly, 2006). Furthermore, clients can be taught how to use thought records and other strategies to solve their own problems without the therapist.

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- *Disputing stereotypes and expectations:* CBT therapists can use the techniques of the approach to help African Americans identify and logically dispute many of the stereotypes and expectations they have internalized from the broader culture—such as having to be twice as good to be good enough—and to increase their personal sense of purpose and opportunities (McNair, 1996).
- *Addressing discrimination:* Therapists can help African Americans mitigate the effects of discrimination by specifically identifying how they cope with discrimination and how it relates to how they perceive and relate to the world (McNair, 1996).
- *Functional analysis:* Functional analysis that examines the symptom in behavioral terms can help to circumvent potential therapist bias and prejudice and can help clients do the same (Kelly, 2006).

Chinese Americans

Therapists have also considered how best to use cognitive-behavioral approaches with Chinese Americans (Hwang, Wood, Lin, & Cheung, 2006). Hwang and colleagues (2006) recommend the following:

1. Explicitly educating clients about the process and goals of therapy to increase their understanding and acceptance.
2. Therapist learning more about the client's cultural background and its significance to the client.
3. Clearly establishing goals and measures of improvement early in treatment to reduce confusion about the process.
4. Focusing on psychoeducational aspects and reinforcing efforts to learn to reduce stigma and empower clients.
5. Using *cultural bridging* to link Western psychological concepts to the client's cultural beliefs and practices (e.g., discussing Qi (life energy) when discussing depression).
6. Presenting therapist as an expert often is helpful to Chinese American clients.
7. Explicitly discussing the therapist–client relationship to clarify roles and set realistic expectations.
8. Attending to cultural differences in communication and deference to authority.
9. Spending extra time creating rapport with client and learning about immigration history and family background.
10. Respecting family orientation of Chinese culture and involving family whenever possible.
11. Being sensitive to social stigma associated with mental illness in Chinese community and the desire to keep diagnosis private.
12. Being patient, because Chinese may not be as comfortable discussing emotions.
13. Being aware of the push-pull between client's culture of origin and the culture of therapy.
14. Integrating Chinese cultural healing traditions, such as QiGong or acupuncture, into treatment plan.
15. Being aware of the ethnic differences in expressing distress, with Chinese notion of self involving a closer relationship between mind/body than in Western culture.

Sexual Identity Diversity

Several authors have considered how to adapt CBT for working with lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) clients (Safren & Rogers, 2001). Safren and Rogers (2001) note that is common that therapists either over- or underestimate the impact that sexual orientation and difference has on a client's presenting problems, and therefore they recommend that therapists begin by examining their own beliefs and schemas related to sexual orientation and identity. Furthermore, Safren and Rogers (2001) encourage CBT therapists to examine the role that societal norms and stigma play in the development of the client's beliefs and schemas.

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When working with LGBTQ youth and adults, therapists need to assess additional areas of stress and functioning:

- Overt acts of harassment, abuse, and violence (Safren, Hollander, Hart, & Heimberg, 2001)
- Internalized homophobia (Safren et al., 2001)
- Existence of social support networks (Safren & Rogers, 2001)
- Development of identity as a sexual minority (Safren et al., 2001)
- Disclosure of sexual orientation to family, friends, and others (Safren et al., 2001)
- Development of platonic and romantic relationships with other gay, lesbian, bisexual, or transgendered persons (Safren et al., 2001)
- Stress due to social stigma (Glassgold, 2009)
- Stress due to concealing stigma and distress (Glassgold, 2009)

Mylott (1994) has identified common irrational beliefs with which gay, lesbian, and bisexual adults frequently struggle; these beliefs are largely informed by societal norms and include:

- I need to be loved.
- I can't stand rejection.
- Because people will often accept or reject me on the basis of my physical attractiveness, age, socioeconomic status, masculinity or femininity, I have to use these same criteria and accept or reject myself.
- It will be awful if I grow old without a lover.
- I can't stand being alone, and since I can't stand being alone, it is better to be in an emotionally and even physically damaging relationship than to be alone.
- When gay people are the victims of homophobia, I have to get very angry and upset about it; I also have to become enraged at homophobic individuals, groups, and institutions.
- I can only accept my homosexuality if I know for certain that it is genetically determined, or that "God made me gay." Otherwise, I cannot accept myself.
- It's awful if people (family, friends, the church, etc.) don't accept my homosexuality.

CBT therapists help clients learn how to adapt more realistic beliefs about their life, sexuality, and others, using techniques such as thought records or Socratic dialogue.

Research and the Evidence Base

Due to their conceptual home in experimental psychology, research is part of the culture of cognitive-behavioral counseling (Beck, 1976) and, therefore, cognitive-behavioral approaches are some of the best researched in the field. More so than any other approach, cognitive-behavioral counselors integrate research into their conceptualization of theory development and intervention, carefully researching specific interventions for specific populations (Beck, 1997).

With an impressive range of applications, cognitive-behavioral therapies dominate the National Institute for Mental Health's list of evidence-based treatments (empirically supported treatments; Chambless et al., 1996). The list includes but is not limited to:

- Cognitive behavioral therapy for panic disorder
- Cognitive behavioral therapy for generalized anxiety disorder
- Exposure treatment for agoraphobia
- Exposure/guided imagery for specific phobias
- Exposure and response prevention for obsessive compulsive disorder
- Stress inoculation for coping with stressors
- Behavior therapy for depression
- Cognitive therapy for depression
- Cognitive-behavior therapy for bulimia
- Behavior modification for enuresis

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- Applied relaxation for panic disorder and generalized anxiety disorder
- Cognitive behavioral therapy for social phobia
- Cognitive therapy for obsessive compulsive disorder
- Exposure treatment for posttraumatic stress disorder
- Stress inoculation training for posttraumatic stress disorder
- Relapse prevention program for obsessive-compulsive disorder
- Behavior therapy for cocaine dependence
- Cognitive therapy for opiate dependence
- Cognitive-behavior therapy for benzodiazepine withdrawal in panic disorder patients
- Trauma-focused cognitive-behavioral therapy

(Detailed descriptions of these and other evidence-based programs can be found on the National Registry of Evidence-Based Practices and Programs website: http://nrepp.samhsa.gov)

Over the years, CBT theorists have modified their approaches based on research outcomes—sometimes dramatically—to incorporate more affective and relational components. Behavioral couples therapy is the premier example of this trend. Because of good short-term but poor long-term outcomes, Neil Jacobson reformulated his couples therapy to include more affective aspects; his new approach is called *integrative behavioral couples therapy* (Jacobson & Christensen, 1996). Similarly, because research indicates that a nonjudgmental therapeutic alliance is crucial, CBT therapists have become increasingly attentive to this aspect of therapy (Beck, 2005).

The meticulous and extensive research efforts of cognitive-behavioralists enable counselors to better know when and how their methods work. In a recent meta-analysis (analysis of the findings from several studies) of well-controlled studies on cognitive-behavioral approaches, Lynch, Laws, and McKenna (2010) found that cognitive-behavioral therapy was not effective in treating or preventing relapse with schizophrenia; it was effective in treating and reducing relapse in depression, although the effect size was small; and it was not effective in preventing relapse in bipolar disorder. To the untrained eye, these may seem like less than flattering findings, but the specificity is unparalleled, with no other approach able to provide similar information or superior findings.

Although CBT has an extensive research history and has the most robust evidence base of any approach, therapists should not assume that it is therefore superior to other approaches in every case or in general. For example, common factors advocates point out that when confounding factors such as researcher allegiance are controlled for, no therapy is consistently found to be superior to any other (Sprenkle & Blow, 2004). Furthermore, for certain concerns such as adolescent conduct issues, systemic approaches have been found to be superior to individual forms of CBT (see Chapter 9). Finally, many therapists have criticized CBT on the basis that its claims to superiority have more to do with the volume of research by CBT proponents than any substantive advantage (Loewenthal & House, 2010).

Along those lines, Miller (2012) reports that a massive effort to transform all mental health in Sweden to CBT resulted in no effect on overall outcome of those diagnosed with depression and anxiety, with over 25% dropping out of treatment. In addition, a significant number of these clients who were not considered disabled prior to treatment *became* disabled, costing the government more money. The Swedish government soon ended its attempt to systematically institute CBT, encouraging new approaches. Thus, although CBT does have the most extensive evidence base in the field, it is by no means a panacea and has by no means provided a simple answer to the question of what works best in therapy.

Cognitive-Behavioral Case Study

A 34-year-old woman of Puerto Rican descent, Maria was recently diagnosed with bipolar disorder, for which she is taking medication and is seeking counseling because she wants to manage her life better. She reports numerous and long bouts of

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depression, the most recent after her second child was born two years ago. During these periods, she can barely drag herself out of bed to go to her job in retail; avoids her friends, who she says don't really care; and watches television all night when she comes home. Her husband tries to cheer her up, but she finds his attempts mostly irritating because "he doesn't really understand me." Her manic episodes take the form of being highly irritated with her husband and children, who she says do nothing to help around the house and expect her to be their maid and cook more than anything. Similarly, she feels that customers at work see her as a doormat. She tries not to lose her temper when she feels "super irritable" and instead becomes snappy and icy cold; she also reports having lots of headaches during these periods. Also during these periods, she stays up and paints nature scenes at night, which is the one thing that she reports enjoying.

Case Conceptualization: Cognitive-Behavioral

Baseline Assessment of Symptomatic Behavior

- *Depression:* Has difficulty waking up in the morning; not motivated to go to work or be with family; isolation from friends and family.
  - *Frequency*: Most days.
  - *Duration*: Lasts for weeks or months at a time since birth of last child two years ago.
  - *Context*(s): At work and at home; only exception is when painting.
  - *Events before*: Fight with husband, difficulty managing children, pressure or stress at work.
  - *Events after*: Either a manic episode or "neutral" or "normal" times.
- *Mania:* Snaps easily at husband, children, coworkers, and customers. Must consciously manage temper to avoid serious interpersonal problems and does so by becoming cold and distant.
  - *Frequency*: Every 2–3 months.
  - *Duration*: 2 days to 2 weeks.
  - *Context*(s): Symptoms at work and home.
  - *Events before*: Typically significant stressor at home or at work (e.g., a major fight with husband or with coworker).
  - *Events after*: Either depression or feeling "normal" again.

A-B-C Analysis of Irrational Beliefs

- *Activating event* ("problem"): Fight with husband over chores.
- *Consequence* (mood, behavior, etc.): Feels depressed, unloved, and unappreciated. Withdraws from family life; goes to bed early and cannot get up in the morning.
- *Mediating beliefs* (unhelpful beliefs about event that result in C): If my husband loved me, he would help more with the children and chores.

Schema and Core Beliefs

- *Selective abstraction:* AF focuses on the one time or handful of times she is treated poorly by others and ignores the overall pattern.
- *Overgeneralization:* AF quickly feels that *all* customers treat her poorly or that her whole family *always* takes her for granted.
- *Magnification and minimization:* AF is quick to magnify disrespectful behavior from others and minimizes acts of generosity and kindness.
- *Personalization:* AF takes the behaviors of customers quite personally when most of their moods and attitudes have little to do with her personally.
- *Core Belief:* One of AF's core beliefs is that if she is respectful and helpful to others, she is entitled to be treated similarly. Although this is an excellent ideal to aspire to, AF has rigidified this ideal to a mandate; when someone fails to treat her as well as she believes she is entitled to, she is harsh and shuts them out of her life. This is contributing to her problems with friends and family.

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BASIC-ID

- *Behavior:* AF has difficulty getting up, alternating with staying up late at night.
- *Affect:* AF has periods of feeling very depressed and worthless as well as feeling irritable and taken advantage of by others.
- *Sensation:* AF reports frequent headaches.
- *Imagery:* AF reports that nature scenes help her feel better about her life and problems.
- *Cognition:* AF believes most all of the people in her life do not really care for or respect her or what she does for them.
- *Interpersonal relationships:* AF often feels as though others are not appreciating her, both at home and at work. She often isolates herself from her friends for similar reasons.
- *Drugs and biology:* AF is taking mood-stabilizing medication for her bipolar disorder.

Treatment Plan: Cognitive-Behavioral

Initial Phase of Treatment

Initial Phase Therapeutic Tasks

1. *Develop working counseling relationship. Diversity consideration:* Ensure a respectful, accountable, and engaged relationship that is attentive to Puerto Rican norms.
   Relationship building intervention:
   a. Use warmth and **empathy** to build rapport; establish **credibility**; demonstrate respect and ensure that AF feels sense of dignity.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Ensure that goals are responsive to communal as well as individualist values that are appropriate for acculturation.
   Assessment strategies:
   a. Obtain **baseline** of problem AF's behavior; **functional analysis** of problem behaviors and thoughts; *DSM* diagnosis.
   b. Assess BASIC-ID to identify effects of bipolar disorder.
   c. Identify specific **schemas** and **irrational beliefs** that relate to her relational issues and bipolar concerns.

Initial Phase Client Goals

1. *Decrease* **hopeless and fatalistic thinking** related to bipolar and relationships to reduce depressed mood and social isolation.
   Interventions:
   a. **Psychoeducation** on bipolar disorder and depressed thinking to create sense of hope that change is possible.
   b. Use **control theory** to motivate AF to *choose* one behavior to engage in over the week that will reduce her social isolation at home or with friends and/or reengage her in normal activity.
   c. Use **functional analysis** to identify one behavior the AF is willing to do to reduce severity of depression and manic symptoms.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* Monitor to ensure that AF is related to in a way that respects cultural and gender values and forms of emotional expression.

(*continued*)

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Assessment Intervention:

a. Use Session Rating Scale; verbally ask AF if sessions are beneficial and if she feels understood by counselor.

Working Phase Client Goals

1. *Decrease* selective **abstraction** and **overgeneralization** that magnify sense of victimization and ill treatment by others to reduce depressive and manic symptoms.
   a. **Disputing** irrational beliefs in session and using **REBT self-help form.**
   b. **Label dysfunctional cognitions** to counter automatic thoughts.
2. *Decrease* rigidity of **core belief/basic "must"** that she must be treated fairly at all times to reduce depressive mood.
   a. **Socratic questioning**, such as "What evidence do you have to support your belief? What evidence is there to the contrary? What might be a realistic middle ground?"
   b. Use **choice theory** to motivate AF to make positive choices: What do you want that you *are* getting? What do you want that you *are not* getting? What are you willing to do differently to get more of what you want?
3. *Increase* positive **self-talk** related to how people are viewing and seeing her to reduce feelings of irritation, depression, and so on.
   a. **Stress inoculation training** and **problem solving training** to help AF learn to interpret others' actions and words in more realistic way.
   b. Use **thought records** to develop alternative thoughts when she encounters a situation in which she feels that others are not appreciating her.

Closing Phase of Treatment

Closing Phase Counseling Tasks

1. *Develop aftercare plan and maintain gains. Diversity consideration:* Include individual, family, and community resources to support AF in maintaining gains; consult with prescribing physician about her progress.
   Intervention:
   a. Use **thought records** and **REBT self-help form** for potential future problems.

Closing Phase Client Goals

1. *Increase* **positive self-talk** about self-worth and relationships to reduce feelings of depression, irritation, and so on.
   Interventions:
   a. **Socratic dialogue** to help AF develop positive views of self and others' behaviors.
   b. Use **thought records** to reinforce realistic self-talk about personal worth and how others see her.
2. *Increase* **proactive and responsible** approach to managing bipolar symptoms to reduce risk of relapse.
   Interventions:
   a. **Socratic dialogue** to increase AF's sense of empowerment and responsibility related to bipolar diagnosis and symptoms; include husband in plan to prevent relapse.
   b. **Thought records** to teach AF how to self-monitor symptoms and identify early warning signs of relapse.
   c. Teaching **mindfulness** to reduce risk of depression relapse.

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Questions for Personal Reflection and Class Discussion

1. Describe how you view thoughts, feelings, and behaviors interacting in your life.
2. Using one of the techniques in the chapter, identify an irrational belief that is problematic in your life.
   - Does identifying the belief help to change your behavior or the intensity of your feelings?
   - If not, what else might need to happen?
3. What possible strengths are there in using a written contract for counseling? What possible limitations?
4. Describe an everyday life situation that effectively served as *in vivo desensitization* (e.g., something you were anxious about but you had/chose to stay in the situation to learn to manage that anxiety). How did it affect you?
5. What strengths does this approach have for working with diverse clients? What limitations?
6. How might clients' acculturation status affect their response to CBT?
7. What might help clients be motivated to do homework exercises in CBT?
8. For what clients might mindfulness practices be most useful?

Online Resources

Associations and Training Institutes

Academy of Cognitive Therapy
www.academyofct.org

American Institute for Cognitive Therapy
www.cognitivetherapynyc.com

Association for the Behavioral and Cognitive Therapies
www.abct.org

Beck Institute
www.beckinstitute.org

Mindfulness Awareness Research Center: UCLA
http://marc.ucla.edu

Mindfulness-Based Stress Reduction Clinic: Jon Kabit-Zinn
www.umassmed.edu/cfm/mbsr

National Association of Cognitive-Behavioral Therapists
www.nacbt.org

Rational Emotive Behavioral Therapy Network
www.rebtnetwork.org

REBT self-help form (thought record exercise)
www.rebtnetwork.org/library/shf.html

William Glasser Institute
www.wglasser.com

Journals

Behavior Therapy
www.elsevier.com/wps/find/journaldescription.cws_home/707105/description#description

Cognitive Therapy and Research
www.springer.com/medicine/journal/10608

International Journal of Cognitive Therapy
www.guilford.com

International Journal of Reality Therapy
www.journalofrealitytherapy.com

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Journal of Behavior Therapy and Experimental Psychiatry
www.sciencedirect.com/science/journal/00057916

Journal of Cognitive Psychotherapy
www.springerpub.com/product/08898391

Journal of Rational Emotive Behavioral Therapy
www.springerlink.com/content/104937

Videos

See the Theory in Action Videos at Cengagebrain.com

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CHAPTER

10

Evidence-Based Cognitive-Behavioral Approaches: Dialectic Behavior Therapy and Trauma-Focused Cognitive-Behavioral Therapy

"In a nutshell, DBT is very simple. The therapist creates a context of validation rather than blaming the patient, and within that context the therapist blocks or extinguishes bad behaviors, drags good behaviors out of the patient, and figures out a way to make the good behaviors so reinforcing that the patient continues the good ones and stops the bad ones"

—Linehan (1993, p. 97)

Lay of the Land

This chapter highlights two widely used contemporary cognitive-behavioral therapy (CBT) approaches: dialectic behavior therapy (DBT) and trauma-focused cognitive-behavioral therapy (TF-CBT). Both are considered evidence-based approaches: the former developed for borderline personality disorder and the second for traumatized children and adolescents. As there are numerous well-regarded evidence-based CBT approaches (see Research and the Evidence Base in Chapter 9), the selection of these two for this chapter is somewhat arbitrary. I selected these because not only are they well established and popular but they also are reported to be frequently required in the places that employ my students. Thus, there is a chance you may find the knowledge from this chapter helpful in your next job interview. Even if your next position does not require one of these two approaches, learning about them should provide a useful template for using any other evidence-based treatment. Compared to other approaches in this book, you will notice these evidence-based ones differ in that they target a specific problem, which results in a far more focused assessment and interventions and a more standardized treatment plan. The downside of this precision is that it has a smaller target audience.

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Dialectical Behavior Therapy

In a Nutshell: The Least You Need to Know

DBT is a well-regarded, widely used evidence-based treatment for borderline personality disorder (Linehan, 1993a). Its primary evidence base has been with borderline personality, but over the years it has been increasingly used with other difficult-to-treat populations, such as eating disorders, depressive disorders, bipolar disorders, substance use disorders, self-harming adolescents, anger/aggressive behavior, and other personality disorders (Chesin & Stanley, 2013; Dimeff & Koerner, 2007; Frazier & Vela, 2014; Miller, Rathus, & Linehan, 2007; Safer, Telch, & Chen, 2009; Van Dijk, Jeffrey, & Katz, 2013). Taking a compassionate stance with clients, the overarching goal of DBT is to increase dialectical behavior patterns in order to increase emotional and behavioral regulation.

DBT is delivered through a comprehensive program of individual and group treatment modalities, which includes phone support between sessions and case consultation for practitioners. In most applications, clients are required to attend weekly individual sessions and weekly group sessions (Linehan, 1993a). In the individual sessions, the counselor establishes a relationship that constantly balances validating and nurturing clients while also maintaining clear limits and demanding behavioral change. In their group sessions, clients are taught a standard curriculum of psychosocial skills. Mindfulness core skills are foundational to the three sets of skills for specific situations: a) interpersonal effectiveness, b) emotion regulation, and c) distress tolerance. These skills are practiced at home with worksheets and reinforced in individual meetings with counselors. The model is specifically designed to target suicidal behaviors, self-harm, and trauma, which are common in persons diagnosed with borderline personality disorder.

The Juice: Significant Contributions to the Field

If you remember one thing from this chapter, it should be …

Dialectical World View

Marsha Linehan (1993a) developed dialectic behavior therapy to more effectively work with persons diagnosed with borderline personality disorder, which was only added to the *Diagnostic and Statistical Manual of Mental Disorders* in 1980 with the publication of the *DSM-III*. In the early 1980s, she worked with a research team to develop an effective treatment for this difficult-to-treat population. She began using traditional cognitive-behavioral therapy methods but found herself also integrating nontraditional and paradoxical ideas found in the work of systemic family therapists (Chapter 11) and Zen Buddhism (see Mindfulness and Acceptance in Chapter 9), such as acceptance of what is, double-bind statements, and matter-of-fact exaggerations. This led to conceptualization of the work in terms of *dialects*: finding a balance between or synthesis of two polar opposites. The classic depiction of dialectics involves: thesis in tension with antithesis resolved by a higher order of synthesis (See Figure 10.1).

In the psychological realm, these sets of opposites may take the form of thoughts (e.g., I love/hate you), emotions (e.g., I am happy and then angry about the same event), or behaviors (e.g., seeking connection then distancing). Linehan found that by assisting clients diagnosed with borderline personality disorder to acknowledge these opposites and then find ways to balance or synthesize them was particularly effective. It became the foundational worldview for this approach.

Dialectic Principles

The dialectical worldview has three primary characteristics (Linehan, 1993a): a) interrelatedness or wholeness, b) polarities, and c) continuous change.

1. *Wholeness:* Similar to the systemic family therapy approaches described in Chapter 11, a dialectic worldview is systemic, consistently seeking to understand all parts as

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segments of a larger, more complex whole. In the case of clients, this includes understanding a person within his/her broader social context, which is also a foundational assumption of systemic, postmodern, and feminist approaches (Chapters 11–14). Linehan (1993a) describes how this is particularly important with clients diagnosed with borderline personality, because many are female and have a more relational sense of self (see Chapter 14) than individuated sense of self. Thus, clients' identities are best understood as inherently interconnected within their intimate relationships and broader sociocultural context.

2. *Polarity:* The principle of *polarity* refers to the systemic notion that all systems, including our interior world, is comprised of opposite tensions (Linehan, 1993a). Even once these tensions are synthesized or resolved, a new order or level of polarities emerges. This view would hold that within dysfunction is function; within powerlessness is power; within distortion is accuracy.
3. *Continuous Change:* The tension of dialectic polarities within a system results in a never-ending process of change that is described as thesis-antithesis-synthesis. The tension between each set of opposites (e.g., good/bad, love/hate, joy/sorrow, etc.) is resolved by shifting to a higher-order perspective that is able to synthesize the prior two opposites through a process of synthesis that is experienced as change (e.g., the synthesis of good/bad is part of the understanding that sometimes a person we love can frustrate us while still loving us). And to add further complexity, this synthesis eventually becomes part of a new set of opposites that will in turn need a synthesis, resulting in a never-ending cycle of change (e.g., sometimes the person I love frustrates me and in that moment they wanted to hurt me because he/she felt threatened; but there is still a foundation of love there). The dialectic assumption of continuous change is similar to that held by solution-focused counseling (Chapter 12).

   One of the most basic assumptions of the DBT approach is that clients (and in fact all of us) simultaneously seek change yet do not want to let go of the old way of doing things; systemic counselors share a similar assumption (see Chapter 11). DBT counselors support clients through this natural dialectic by supporting self-preservation and self-transformation simultaneously (Linehan, 1993a).

Dialectic Failure

In DBT, borderline personality disorder is viewed as a failure of a person to effectively resolve the dialectic tensions that characterize the human mind, relationships, and life more generally (Linehan, 1993a). A signature characteristic of borderline thinking is "splitting," seeing people and situations as all-good or all-bad; this is a straightforward example of dialectic failure, since nothing is entirely good or bad. Similarly, another borderline characteristic is to focus on the polarity of self-other; dialectic failures in seeing how self and others are interrelated often results in the person with borderline traits feeling profoundly isolated and alienated one moment and intensely connected the next moment. The goal of treatment is to enable clients to effective engage dialectic tensions and transcend them through synthesis.

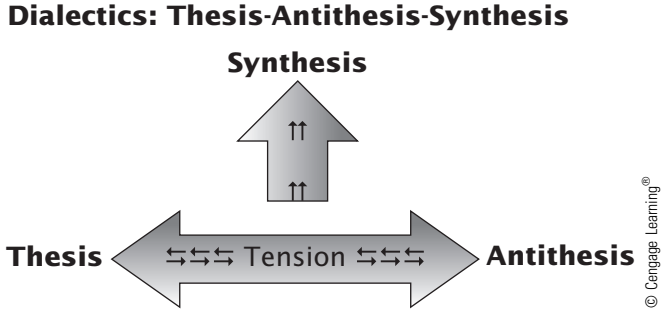

FIGURE **10.1.** Diagram of Dialectic Process

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Rumor Has It: The People and Their Stories

Marsha Linehan Marsha Linehan developed DBT in the 1980s through her research on suicidal and self-harming behaviors at the University of Washington (Linehan, 1993a). She was one of the first to integrate Zen concepts of acceptance into Western therapy approaches. She directs several institutes where she continues to develop this approach for use with borderline and other disorders: the Behavioral Research and Therapy Clinics at the university, the Linehan Institute of Behavioral Technology, and Behavioral Tech Institute. She has been awarded some of the highest honors in the field for her groundbreaking work.

Big Picture: Overview of Counseling Process

Stages of DBT

DBT is conducted in three phases as well as a pretreatment stage; each stage has predefined goals that are relatively standard for clients diagnosed with borderline personality disorder (Linehan, 1993a). Similar models have been developed for other populations, including eating disorders (Safer et al., 2009), mood disorders (Chesin & Stanley, 2013; Van Dijk et al., 2013), anger and aggression (Frazier & Vela, 2014), and suicidal adolescents (Miller et al., 2007). The pretreatment stage involves obtaining client agreement to the terms and length of treatment. In the first stage, the focus is on reducing suicidal and self-harming behaviors, therapy-interfering behaviors, and quality of life behaviors, such as substance abuse, abusive relationships, or overspending. In addition, the first stage targets include increasing the use of coping skills taught in the skills group.

In the second phase of DBT, the focus is on resolving past trauma, which departs from more traditional forms of trauma treatment, which require that trauma be taught first (Linehan, 1993a). However, Linehan found that most clients who qualify for borderline personality disorder become quickly overwhelmed and more suicidal if trauma is addressed before the crisis issues in stage one are addressed and the client gains new coping skills. In the third stage, the goals are to increase self-respect and take action toward achieving the client's personal life goals. These stages are typically not purely linear, with clients typically moving back and forth between stages when new stresses or crises arise.

Stages of DBT

Pretreatment Stage
- Obtain commitment to treatment

Stage 1: Reduce Crisis Behaviors and Increase Coping Skills
- Reduce suicidal and self-harming behaviors
- Reduce behaviors that disrupt the counseling process
- Reduce behaviors that significantly interfere with quality of life
- Increase behavioral coping skills (from skills group curriculum; Linehan, 1993b)
  - Core mindfulness skills
  - Interpersonal effectiveness
  - Emotional regulation
  - Distress tolerance
  - Self-management

Stage 2: Reduce Trauma-Related Symptoms
- Reduce trauma-related symptoms

Stage 3: Increase Life-Enriching Behaviors
- Increase self-respect and self-validation
- Increase action toward achieving personal life goals

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Modes of DBT

DBT has four primary treatment components or *modes* that are included in most research trials: a) individual counseling, b) group skills training, c) phone consultation, and d) case consultation for the treatment providers (Linehan, 1993a). In addition, ancillary treatments such as psychopharmacology or substance abuse treatment may be recommended to clients and provided in the form of a referral for these additional services.

Individual Counseling Sessions The client's individual counselor serves as the primary person overseeing treatment, helping the client replace borderline behaviors with more effective ones. Typically, clients meet once per week with their primary counselor for 45–50 minutes; however, during crisis, or for more severe situations, sessions may be twice per week and/or 90–120 minutes long.

Group Skills Training Additionally, in the first year of treatment, Linehan requires clients to also attend a weekly two-hour group skills training to learn alternative coping skills. This group evolved because Linehan found it exceptionally difficult to focus on skills training in individual sessions due to the ongoing crises that characterize the borderline diagnosis. An optional supportive group process is available in Linehan's clinics after a client has successfully completed the one-year group.

Telephone Consultation In Linehan's model, the individual counselor is also available by phone to clients between sessions to guide clients in applying their skills to crises that arise during the week. This phone consultation is especially critical for clients who self-harm or have suicidal behaviors.

Case Consultation for Counselors Because the treatment of borderline personality disorder can be extremely stressful for the health care provider, structured implementation of DBT involves weekly case consultation to help counselors reflect on how their behaviors affect the client. For example, a common problem addressed in these groups is setting limits with clients. Persons with borderline traits often push boundaries with counselors, and some make unrealistic demands; many counselors respond by having overly rigid boundaries, which may exacerbate the client symptoms, while others begin down a slippery slope of giving in to these demands. The case consultation group helps counselors successfully navigate these difficult situations to identify what is reasonable, fair, and therapeutic, and what is not.

Ancillary Treatments Depending on the needs of an individual client, other ancillary treatments may be recommended and the client referred for the suggested services. These may include psychopharmacology, substance abuse treatment, hospitalization, vocational counseling, hospitalization, day treatment, among others (Linehan, 1993a).

Making Connection: Counseling Relationship

The counseling relationship in DBT is characterized by three sets of dialectic tensions (did you expect anything less?):

Dialectic of Acceptance and Change

The *dialectic* between *acceptance and change* is a pervasive characteristic of the counseling relationship (Linehan, 1993a). The acceptance piece involves a radical form of acceptance that accepts the client and counselor exactly as each is in the present moment. "This is not an acceptance in order to bring about change; otherwise, it would be a change strategy" (p. 109). Instead, DBT acceptance involves embracing the good and bad without judgment or a need to change anything. Yet, paradoxically, the counselor balances this pole of acceptance with a recognition that change is continuous and necessary. The counselor embodies this synthesis through a balance of warmth and a

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willingness to compassionately accept clients as they are in each moment (which can be incredibly difficult with a client exhibiting borderline traits), while at the same time recognizing that change is inevitable and necessary.

Dialectic of Unwavering Centeredness and Compassionate Flexibility

The second *dialectic* that characterizes the counseling relationship is that of *unwavering centeredness and compassionate flexibility* (Linehan, 1993a). Unwavering centeredness refers to a clarity of mind that is confident in itself and stays focused on the long-term goals. In the face of constant crisis, unwavering centeredness is the calm in the middle of the storm. This is counterbalanced by compassionate flexibility, which is the ability to be open to influence from the client as appropriate. Compassionate flexibility allows for the counselor to take in relevant information from the client and adjust accordingly, allowing for responsiveness and creativity. Thus, rigidly consistent boundaries are not the goal; but rather a compassionate responsiveness that allows for flexibility, while at the same time maintaining an unwavering clearness of purpose and focus.

Dialectic of Nurturing and Benevolent Demanding

The third *dialectic* is the balance between *nurturing and benevolent demanding* (Linehan, 1993a). The DBT counselor nurtures clients by providing coaching, assistance, and educating, while maintaining a position of believing the client can change. This nurturing stance is balanced with a commitment to push clients to take care of themselves and solve their own problems in areas where they are able, or learning to be able. The dialectic tension here is to challenge the client to grow while simultaneously providing reassuring support. This is a dynamic and fluid process, because a client's abilities (should hopefully) change as counseling progresses, with the client needing varying levels of firmness and gentleness throughout the process.

Client Agreements

Most mental health professionals use an informed consent agreement at the beginning of treatment. DBT counselors have a more extensive approach due to the types of problems that arise when working with clients diagnosed with borderline personality disorder. During the first few sessions, counselors go over several agreements that are done at minimum orally; these can also be done in writing (Linehan, 1993a; samples in Safer et al., 2009).

- *One-Year Commitment:* Over the first few sessions, the counselor explicitly obtains client agreement a) to work together (it should not be assumed), and b) for how long. In most circumstances, a one-year agreement is made, which is renewable annually upon the agreement of both parties.
- *Circumstances of Unilateral Termination:* The counselor also explicitly outlines what behaviors would lead to unilateral termination on the part of the counselor. The only formal termination rule is that if a client misses four sessions in a row of either skills training or individual session, the client is out of the program until the end of the contract period, at which point resuming services may be negotiated. If other situations arise that may lead a counselor to ending services—such as the counselor feeling pushed to his or her limits or not believing she/he is able to help further—the counselor provides sufficient warning so that the client has a reasonable opportunity to change the problem behaviors. Similarly, if the client wants to terminate before the contract period is up, the client agrees to come in for a session to discuss the proposed termination.
- *Attendance:* The counselor also obtains client agreement on attending weekly individual and group sessions regardless of the client's mood or wish to avoid a certain topic.
- *Suicidal and Self-Harming Behaviors:* Another required agreement is that the client agree to work toward resolving her life problems without self-harming or suicidal behaviors. If the client does not agree to this, DBT may not be considered appropriate.

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- *Interfering Behaviors:* The client is also asked to agree to work on problems that interfere with the progress of treatment, especially those that relate to collaborating with the counselor and working toward stated goals.
- *Skills Training Group:* Finally, all clients must agree to attend the skills training group for the first year.

Practitioner Agreement

The counselor also makes several other agreements with the client (Linehan, 1993a; examples in Safer et al., 2009):

- *"Every Reasonable Effort":* The counselor agrees to make "every reasonable effort" to provide compassionate, competent care. However, the counselor should make clear that reasonable effort does not mean that the counselor can solve client problems, keep them from harming themselves, or will be personally available 24/7 for crisis situations.
- *Ethical Conduct:* Counselors let their client know that they will abide by the ethical standards of their profession. Although this may seem obvious, Linehan (1993a) states that many of her clients who often have long histories of treatment also report past behaviors by professionals that do not adhere to professional conduct.
- *Personal Contact:* The counselor must agree to attend sessions, conduct sessions for the agreed-upon length, be available at reasonable hours by phone between sessions, and provide reasonable coverage when on vacation or unavailable.
- *Respect:* DBT counselors also explicitly discuss their commitment to show respect for the client throughout treatment.
- *Confidentiality:* The counselor also discusses confidentiality and its limits in the given treatment environment. This includes keeping private more sensitive information from the treatment team unless necessary for treatment.
- *Consultation:* Finally, DBT counselors let clients know that they commit to obtaining consultation from a supervisor or peers to ensure that they are receiving feedback on their role and professional behaviors in the process.

The Viewing: Case Conceptualization

Foundational Assumptions

Linehan (1993a) describes eight foundational assumptions of DBT for working with borderline personality disorder:

1. Clients are doing the best they can.
2. Clients want to get better.
3. Clients need to be motivated to change and work hard to change.
4. Clients may not have caused their problems but need to solve them anyway.
5. The lives of persons with borderline and suicidal traits are unbearable as currently lived.
6. Clients must learn new behaviors in all areas of life in which they are having problems.
7. Clients cannot fail in counseling.
8. Counselors working with clients diagnosed with borderline personality disorder need support.

Emotional Dysregulation

Linehan conceptualizes borderline personality disorder as primarily a disorder of emotional regulation (Linehan, 1993a). *Emotional dysregulation* results from having high levels of emotional vulnerability and intensity combined with an inability to modulate one's emotions. Persons with borderline personality are described as *emotionally vulnerable*, meaning they have high sensitivity to emotional stimuli and take longer than average to return to their emotional baseline. Their emotional reactions are typically extreme and more intense than the average person.

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DBT counselors first assess for emotional dysregulation by identifying problematic behaviors that arise when the client is unable to regulate emotions; they have three general categories for these behaviors:

- Suicidal and Self-Harming Behaviors
- Therapy-Interfering Behaviors
- Quality-of-Life-Interfering Behaviors

Suicidal and Self-Harming Behaviors

As an approach designed first and foremost to work with clients diagnosed with borderline personality disorder (a disorder that often is characterized by suicidal and self-harming behaviors), addressing suicide and self-harm is part of the initial case conceptualization. When working with this population in particular, suicidal assessment should be an ongoing process, especially when new crises arise. Linehan describes five forms of suicidal behaviors targeted in DBT in the early phase of treatment: a) suicidal crisis behaviors, b) self-harming acts and parasuicidal acts, c) suicidal ideation and communications, d) suicide-related beliefs, and e) suicide-related affect.

Suicide Crisis Behaviors Suicide crisis behaviors refer to behaviors that indicated that client is at high risk for suicide, such as believable threats of suicide, preparatory actions, and lethal means. Linehan maintains that "borderline individuals usually have good reasons for wanting to die" because their lives become unbearable (p. 125). However, DBT counselors always advocate for life, even when a client has convincing arguments to the contrary. In these circumstances, counselors take all actions allowable by law to stabilize and protect the lives of clients, including involuntary hospitalization.

Parasuicidal and Self-Harming Acts Linehan uses Kreitman's (1977) definition of parasuicide to distinguish certain behaviors from suicidal crisis behaviors. In Kreitman's model, parasuicidal acts refer to a) nonfatal, intentionally self-injurious behavior that may result in physical harm up to and including death, or b) the ingestion of substances with the intent to cause harm or death. DBT counselors assess for these behaviors and target them for immediate intervention early in treatment. The counselor works with the client to end these behaviors as part of the counselor's compassion for the client and commitment to help the client.

Suicidal Ideation and Communications/Threats Another early phase goal is to reduce suicidal ideation and communications, both of which are common in persons diagnosed with borderline personality. These goals may include reducing suicidal fantasies, urges, planning, and threats. Linehan (1993) recognizes that for some the possibility of suicide has a reassuring quality: if things get unbearable, there is still another way out. Therefore, suicidal ideation is only directly targeted for change when it is new, extremely intense, associated with self-harming or suicidal behaviors, or interferes with clinical progress. In contrast, suicidal threats are always targeted directly for change because of the implication for interpersonal relationships and the counseling process.

Suicide-Related Beliefs DBT counselors take time to assess the client's beliefs and expectations regarding suicidal and self-harming behaviors as problem solving measures. They may have both realistic and unrealistic thoughts about suicide, which include getting revenge, seeking attention, escaping their own pain, or alleviating that of others. Similarly, clients report engaging in self-harm because it brings temporary relief from their suffering with the benefit of attention and often sympathy. These beliefs are targeted when they are realistic and support parasuicidal and suicidal behaviors.

Suicide-Related Affect The final area assessed in DBT related to suicide is client affect when discussing suicide and self-harm. Clients can exhibit and report a range of moods, including peace, relief, anger, shame, or even sexual excitement. If these moods directly affect parasuicidal and suicidal acts, they are directly targeted for change.

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Therapy-Interfering Behaviors

Therapy-interfering behaviors refer to behaviors that make it nearly impossible for the client to receive treatment (Linehan, 1993a). These behaviors are categorized as: a) nonattentive behaviors, b) noncollaborative behaviors, and c) noncompliant behaviors.

Nonattentive behaviors Nonattentive behaviors involve behaviors that result in the client not being physically or otherwise present for treatment. This may include dropping out of treatment, threatening to drop out, cancelling frequently, frequent hospital admissions, excessive suicidal/self-harming threats, constant crisis, among others.

Noncollaborative behaviors Clients engage in noncollaborative behaviors when they lie to their counselor, refuse to speak, withdraw emotionally, argue frequently, or distract from important topics of discussion.

Noncompliant behaviors Since DBT is a very active treatment, clients need to be willing to actively participate. Noncompliant behaviors involve not doing homework, not keeping agreements, not complying with recommendations, and such.

Quality-of-Life-Interfering Behaviors

Quality-of-life-interfering behaviors refer to a wide range of poor life choices that significantly prevent the client from living a fulfilling life and achieving their life goals (Linehan, 1993). Common examples of quality-of-life-interfering behaviors include:

- *Substance and alcohol abuse*, including abuse of prescription medications.
- *Risky sexual behavior*, including unprotected sex and excessively promiscuous sex.
- *Criminal and illegal behaviors*, such as shoplifting or selling drugs.
- *Extreme financial difficulties and excessive spending*, including gambling or failure to pay bills.
- *Severely problematic and/or abusive interpersonal relationships patterns*, such as staying in a violent relationship or frequently cutting off relationships.
- *Occupational or school-related problematic behavior patterns*, such as irregular attendance, frequent quitting, or inability to consistently perform.
- *Health and illness-related problematic behavior patterns*, such as ignoring health issues or noncompliance with health recommendations.
- *Housing-related problematic behavior patterns*, such as living in a car or frequently switching housing situations.
- *Mental health-related problematic behavior patterns*, such as dropping out of treatment or not complying with medication regimes.

In the case study at the end of the chapter, April is a struggling actress who is struggling with several quality-of-life-interfering behaviors, including difficulty keeping a job, being in an abusive relationship, and risky sexual behavior. After her relatively mild parasuicidal behaviors and therapy-interfering behaviors are addressed, these areas of life functioning will be the next targeted for intervention. Since she has several, the counselor and client work together to decide on which one to target first.

Invalidating Environments

In her work with persons diagnosed with borderline personality disorder, Linehan (1993) noticed that many grew up in or currently live in *invalidating environments*, contexts in which a person's attempts to express emotion and personal meanings are met with invalidating responses. Invalidating responses include denying, minimizing, mocking, contradicting, punishing, or ignoring the client's reported reality or desire. Typically, these invalidating responses both a) deny the client his/her experience, and b) attribute negative personality traits (e.g., "that person was not mean to you; you are just overly sensitive"). These invalidating responses can involve relatively minor daily matters, such

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as a fight over a toy with a sibling, or more significant issues, such as denying sexual abuse. In general, invalidating environments prohibit the expression of negative emotions and require the individual to instead manage his/her own needs. In general, these families place high value on achievement, mastery, and positive mood while harshly punishing negative emotions and failure. This is similar to the "expressed emotion" dynamic that characterizes families with children diagnosed with depression and schizophrenia; Linehan (1993a) adds to this the dynamic of not validating the client's actual state.

Linehan (1993a) maintains that these environments have significant negative consequences that result in poor emotional regulation. First, by not labeling or recognizing negative emotions, children in invalidating environments do not learn how to identify their emotions and therefore are unable to manage them. These children do not learn distress tolerance, only suppression. Furthermore, in these environments, extreme emotional displays are often necessary for children to be recognized at all; thus, these extreme reactions are behaviorally reinforced. Lastly, invalidating environments leave children unable to trust themselves, their experiences, or interpretations; they therefore look outside for social cues for how to think and feel, resulting in a highly unstable identity.

Linehan (1993a) identifies three common types of invalidating families: a) chaotic, b) perfect, and c) typical. As the name indicates, chaotic families refers to families in which little attention is given to the children, often due to substance abuse or financial problems. In perfect families, the parents harshly punish the expression of negative emotions; this may be due to the parents' own level of stress, lack of understanding, or wanting to avoid spoiling a child. The typical family refers to the "average" American family that adopts the Western value of individuation and self-control. In these families, some children may not be greatly affected by the invalidating environment. However, the child with a more sensitive temperament may be severely affected. Finally, it is important to note that a vicious cycle easily occurs between a vulnerable child and the family: the more the family invalidates, the more dysregulated the sensitive child becomes, which leads to more invalidation by the family and thus more dysregulation in the child. Thus, a slightly vulnerable child within a mildly invalidating family can spiral out of control, making each more extreme.

Trauma History and Sexism

Since trauma histories, particularly sexual abuse, are extremely common in persons diagnosed with borderline personality disorder (Ferraz et al., 2013), DBT counselors routinely screen for childhood abuse and neglect as well as current abusive relationships or other traumas (Linehan, 1993a). With the exception of current traumatic relationships, most trauma, especially childhood trauma, is targeted in the second phase of DBT treatment, after clients have developed sufficient coping skills to do the emotional work necessary to work through these difficult issues.

In addition, as approximately 75% of persons diagnosed with borderline personality disorder are female (APA, 2013), Linehan (1993a) considers gender issues, specifically sexism, an important area of assessment. In addition to the most extreme example, sexual abuse, other forms of sexism create invalidating environments for women, including impossible ideals for being simultaneously independent and dependent, and lack of validation for women whose talents do not conform to gender stereotypes.

Targeting Change: Goal Setting

Overarching Goal: Increase Dialectical Behavior Patterns

The overarching goal of DBT is to increase dialectical behavior patterns, which include cognitive and emotional patterns (Linehan, 1993a). All goals and interventions aim to enable clients to simultaneously engage both sides of a polarity and work toward transcending problematic dichotomies through synthesis of the polarities. This synthesis does not always mean that black-and-white polarities are turned to gray. Often, the resolution involves recognizing that the two polarities are *both true*: my partner loves me AND cannot give me what I want in a particular situation. Furthermore, these two

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seeming polarities can actually be part of the same thing: a long-term, loving relationship. Thus, the overarching goal is to help clients learn to engage in thinking that allows them to more effectively manage the inherent paradoxes of living.

Primary Goals (Behavioral Targets)

When working with clients diagnosed with borderline personality disorder, DBT counselors use the following *primary behavioral targets* to structure their treatment with clients (Koerner, 2012; Linehan, 1993a; 1993b); these are in a *hierarchy*, with the first goals always targeted first, whether in an individual session or across treatment as a whole:

Hierarchy of DBT Goals/Treatment Targets

1. Decrease suicidal behaviors (Stage 1)
2. Decrease therapy-interfering behaviors (Stage 1)
3. Decrease behaviors that reduce quality of life (Stage 1)
4. Increase behavioral skills (Stage 1)
   a. Core mindfulness skills
   b. Distress tolerance skills
   c. Emotion regulation skills
   d. Interpersonal effectiveness skills
5. Decrease behaviors related to trauma (Stage 2)
6. Increase self-respect (Stage 3)

Secondary Goals (Behavioral Targets)

In addition to the above primary goals, DBT counselors assess whether the following *secondary behavioral targets* are necessary for the client to achieve the primary goals (Linehan, 1993a). In other words, depending on the needs of an individual client, the counselor may add the following secondary goals to help clients achieve their primary goals:

1. Increasing emotional modulation while decreasing emotional reactivity
2. Increasing self-validation while decreasing self-invalidation
3. Increasing realistic decision making while decreasing crisis-generating behaviors
4. Increasing emotional experiencing while decreasing inhibited grieving
5. Increasing active problem solving while decreasing passivity
6. Increasing accurate communication of moods and competencies while decreasing mood dependency of behavior.

The Doing: Interventions

Validation

One of the two core strategies (problem solving being the other), *validation* refers to the counselor clearly and directly communicating to clients that their behavior makes sense and is understandable in the current context and/or life history (Linehan, 1993a). Validation in DBT has been compared to humanistic approaches (Chapter 6), which emphasize honoring the client's subjective lived experience without pathologizing (Hadjiosif, 2013). Because many clients have experienced invalidating environments elsewhere, the process of direct validation is central to the approach.

There are three steps to the basic validation process (Linehan, 1993a):

1. *Active Observing:* The counselor listens without preconceived notions to what the client says and observes the client's affect and behaviors in the moment. While observing and listening, the counselor is trying to identify the unstated assumptions, thoughts, or emotions that help make sense of the client's viewpoint.
2. *Reflection:* Similar to person-centered counselors, the DBT practitioner empathetically summarizes the client's spoken and underlying feelings, thoughts, and expectations so that the client feels deeply understood. While reflecting the client's experience, the counselor frequently checks with the client to make sure the reflection is accurate by asking "Is that right?" or "Have I understood?"

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3. *Direct Validation:* Finally, the counselor identifies the wisdom or validity of the client's perspective given the current situation and/or the client's history. The counselor always assumes that the behavior makes sense within the given context, similar to systemic counselors (Chapter 11), and strives to understand how exactly the behavior fits with the context. Even when only a small part of the response is valid, the therapist identifies and validates it; problem solving strategies can later be used to address any dysfuncational behaviors. This direct validation allows clients to then learn to validate themselves. There are two primary forms of direct validation: a) describing how the current behavior makes sense in terms of past experiences, and b) describing how the client's behavior makes sense given the current situation.

Examples of Validation

- "I can see how such a comment from a friend would hurt." [validate emotions in current situation]
- "Given your experience of having been abused as a child, your fear makes sense." [validate based on history]
- "It makes sense that you are feeling angry about his not showing up; especially because you have history of other important people not showing up for you in your life." [validate current situation and past history]
- "I can see that this event was very important to you. So, even if others do not think it is a big deal, it is a big deal for you." [validate current situation]

DBT clinicians validate only what they sincerely believe is valid; their validation is always genuine (Koerner, 2012). They *actively* search and listen for the valid in a client's story or experience. Validation is particularly useful when the client is emotionally dysregulated in session; the experience of being validated can help the client regulate and eventually learn to self-regulate. When validating clients who are dysregulatated in sessions, counselors focus on (Koerner, 2012):

- The importance or seriousness of the problem
- The difficulty of the task
- Client's emotional pain
- Client's reasons for feeling out of control
- Wisdom in the client's ultimate goal for a particular act/feeling
- Whatever is justifiable given the situation, logical inferences, or some authority/guidelines
- Whatever is an appropriate means to an end

Emotional Validation Strategies

Emotional validation is used to help clients process intense and difficult emotions or to assist a client with inhibited emotions. Strategies for emotional validation include (Linehan, 1993a):

- Providing opportunities for the client to express emotions in session
- Teaching client to mindfully observe and label emotions
- Teaching client to more accurately read the emotions of others
- Directly validating client emotions

Behavioral Validation Strategies

Behavioral validation refers to directly communicating the understandability of a particular client behavior; this is done in virtually every session. These strategies include (Linehan, 1993a):

- Teaching client to mindfully observe and label behaviors
- Identifying the "should" (for self or others) behind their behaviors
- Countering the "should" in circumstances when the client is denying "what is"

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- Accepting the "should" in circumstances when a behavior "should" happen, in order to produce a certain outcome
- Validating client disappointment in her or his own behavior (if it is expressed), while still validating that the behavior is understandable

Cognitive Validation Strategies

Cognitive validation refers to validating client beliefs and thoughts and also helping clients identify the underlying assumptions or rules. Cognitive validation strategies include (Linehan, 1993a):

- Eliciting and reflecting thoughts and their underlying assumptions
- Distinguishing facts of the situation from client's interpretation
- Identifying the "kernel of truth" in the client's perception
- Acknowledging "wise mind" whenever possible
- Respecting different values between client and counselor

Cheerleading Strategies

Because persons diagnosed with borderline personality disorder are often hopeless, DBT counselors have found that *cheerleading strategies* are helpful in providing encouragement and reinforcing client strengths (Linehan, 1993):

- Assuming that clients are always doing the best they can in any given moment
- Providing encouragement and expressing confidence that the client will be successful
- Focusing and reinforcing the client's existing and developing capabilities
- Countering negative external criticism from others
- Providing positive praise and reassurance
- Provide realistic cheerleading that is dialectically counterbalanced with recognition of problems
- Staying near and available throughout the process

Mindfulness and Wise Mind

Linehan (1993a; 1993b) was one of the first to include mindfulness as part of a therapeutic model. *Mindfulness skills* are considered "*core skills*" in that they are the foundation for many of the other skills taught in DBT. Mindfulness skills are used to promote *wise mind*, the dialectic balance of two extreme states of mind: reasonable mind (intellectually handling of a situation) and emotion mind (emotionally handling of situation).

Core Mindful "What" Skills Helping to reduce impulsive or mood-dependent behaviors, mindfulness "what" skills refer to teaching the client to mindfully attend to three distinct processes:

1. *Observe* emotions, thoughts, behaviors and events, especially those targeted for change.
2. *Describe* thoughts, feelings, and experiences with words and separate the client's lived experience from precipitating events.
3. *Participate* without self-consciousness so that one is fully and spontaneously immersed in the events as they unfold, including thoughts, emotions, and/or behaviors.

Core Mindful "How" Skills Designed to increase clients' effectiveness in responding to difficult situations, mindfulness "how" skills refer to how clients engage in three processes:

1. *Nonjudgment:* Avoid judging things as good or bad and instead accept what is.
2. *One-Minded:* Focus on doing one thing at a time, avoiding distractions so that the mind can concentrate.
3. *Effectiveness:* Identify what response is likely to effectively resolve an issue and help meet one's true objective, rather than react based on what one thinks is fair, right, or just.

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Interpersonal Effectiveness Skills

Interpersonal effectiveness is one of the main sets of skills taught in DBT skills groups (1993b). This set of skills involves learning behaviors that support healthy relationships and build self-respect. Interpersonal effectiveness skills are taught by means of cognitively challenging myths about interpersonal relationships (e.g., "I can't stand it if someone gets upset with me," p. 118), analyzing options for making low- versus high-intensity requests, and practicing interpersonal effectiveness skills in the community. In addition, specific sets of skills are taught for asking for what one wants and for maintaining healthy relationships. Clients are given specific worksheets (available in Linehan, 1993b) to practice their skills as conflicts with others arise during the week.

Emotional Regulation Skills

Emotional regulation skills are taught to reduce emotional lability that characterizes borderline personality disorder and other forms of emotional distress (Linehan, 1993a). These skills include learning to use mindfulness to identify and label one's moods and then separating the client's interpretation from the event itself. In addition, clients identify and reduce physical or environmental stressors that make them more susceptible to "emotion mind," such as insomnia, poor eating, or multitasking. Conversely, they are encouraged to increase activities that promote positive emotions. In the skills training group, participants are provided extensive handouts for naming emotions as well as cognitive worksheets for analyzing stressful events, logging emotions over the course of a given day, and taking steps to reduce painful emotions (available in Linehan, 1993b).

Distress Tolerance Skills

One of the first examples of introducing acceptance into a cognitive-behavioral approach, *distress tolerance skills* are used to help clients learn how to effectively respond to the inevitable stresses and crises one experiences in life: "DBT emphasizes learning to bear pain effectively" (Linehan, 1993a, p. 147). Grounded in the core mindfulness skills, distress tolerance involves acknowledging either distressing internal or external events without insisting that others, oneself, or life be different (Linehan, 1993b). This acceptance does not necessarily mean approval but rather a mindful acknowledgement that the situation exists. This is particularly important in cases of abuse; acceptance in such circumstances involves acknowledging that one is experiencing abuse and may need to take action to protect oneself. In the DBT skills course, distress tolerance skills include skillful distraction, self-soothing using the five senses, imagery-based exercises, pros/cons lists, and mindful breath exercises (available in Linehan, 1993b).

Behavioral Chain Analysis Strategies

A key problem solving set of skills, *behavioral chain analysis* is used to analyze problem behaviors so that they can be altered (Koerner, 2012; Linehan, 1993a). In DBT, behavioral and insight analysis are taught separately to facilitate learning by practitioners; however, in reality they are often done together. Steps to DBT behavioral analysis include:

1. **Definition:** Behaviorally defining the problem behavior, including duration, frequency, and intensity (e.g., crying whenever client feels even slightly criticized by partner).
2. **Chain:** Conducting a step-by-step chain analysis of a specific instance of the behavior, beginning with precipitating events and prior physical vulnerabilities and ending with the consequences. A behavioral chain generally includes:
    - *Physical vulnerabilities:* Sleeping, eating, substances, medications, location, etc. (e.g., client didn't sleep well night before)
    - *Precipitating events:* Trigger event and related circumstances (e.g., client felt rejected by another friend's lack of response to an email earlier in the day; partner asked, "are you going to wear that?")
    - *Sequence of problem events:* Detailed step-by-step description of problem behavior (e.g., client started crying; yelled at partner; refused to go out; partner tried to calm client down for a few minutes then gave up….)

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- *Consequences:* Psychological, emotional, physical, relational (e.g., angry at partner for days; feel ugly; distance in relationship; overeat; want to cut, etc.)

3. **Hypothesis:** Develop with the client a hypothesis about the factors contributing to problematic behaviors (e.g., client more sensitive when sleep-deprived; transfers stress from one relationship to another, etc.)

Try It Yourself

Either alone on paper or with a partner, construct a behavioral chain using the steps above. What is your hypothesis? Did any new insights arise from the chain analysis?

In the case study at the end of the chapter, the counselor creates a behavioral chain analysis for April, targeting her interactions with her supervisor at the restaurant where she works. This chain begins with the supervisor making a request to do a task she finds menial: clean the silverware and put out the napkins. She responds to him with a sarcastic remark, which begins the familiar cycle she has of wanting to leave a job shortly after getting it. In the chain analysis, she and the counselor note that she had slept poorly the night before and had also engaged in risky sexual behavior, which may have contributed to the episode.

Insight Strategies

In DBT, *insight strategies* are interpretations used to highlight patterns and increase awareness related to specific behaviors targeted for change (Linehan, 1993a) and are often combined with behavioral chain analysis. DBT counselors have three guidelines for *what* to interpret:

1. *Behaviors specifically targeted in DBT* for change (e.g., suicidal behaviors, therapy-interfering behaviors, etc.).
2. *Public behaviors* in session or as reported by client out of session (rather than thoughts, unconscious motives, etc.).
3. *Present behaviors* rather than past behaviors.

For example, a DBT counselor may interpret attendance patterns to highlight that a client misses sessions when certain topics are planned for discussion: "I have noticed that whenever we are planning to discuss your relationship with your partner, you seem to have a conflict with the next session or have a crisis that prevents us from discussing your partner. Do you think there may be a pattern we need to address here? It seems like there might be something you are afraid of or worried about?"

Much of the success of a given interpretation depends on *how* the insight is delivered, which can be a significant challenge. DBT counselors strive to use nonpejorative terms when offering insights and try to offer interpretations in the way most likely to be received as supportive. In addition, interpretations typically try to link *current behaviors* to *current events*.

Solution Analysis Strategies

Similar to other cognitive behavioral approaches, DBT counselors assume that insight does not readily translate to action. Therefore, DBT counselors facilitate *solution analysis* (Linehan, 1993a) or *task analysis* (Koerner, 2012) with clients when they are ready to identify more effective solutions to their problems. These analyses result in mini-treatment plans for a specific problem, such as crying spells, cutting, or shutting down emotionally. This process involves five basic steps:

1. *Identify goals, needs, and desires:* Often when working with persons diagnosed with borderline personality disorder, clients have great difficulty identifying needs and wishes or listing death as a goal. Thus, the counselor often must work closely with the client to identify the underlying need behind some of the client's stated goals, such as wanting to not experience pain as a goal, or behind cutting or suicidal ideation.

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2. *Generate solutions:* Next the client and counselor work together to generate a list of possible solutions. Often a behavioral analysis of the problem situation is helpful in identifying points for possible alternative responses.
3. *Evaluate solutions:* The client and counselor then work together to evaluate the solutions based on a) potential effectiveness, and b) potential obstacles.
4. *Choose and implement solution:* Finally, the client chooses a solution to implement.
5. *Troubleshooting:* Before the client leaves to try the solution in daily life, the counselor and client troubleshoot by identifying all of the likely challenges and trying to identify potential remedies.

Try It Yourself

Find a partner and take turns analyzing potential solutions to a current problem. What part of this process was the most challenging? What would help to motivate you to take action on this solution?

Commitment Strategies

As part of the problem solving procedures, DBT counselors directly intervene to increase client *commitment* to DBT goals and specific therapeutic tasks (Linehan, 1993a). Strategies to increase client commitment are used throughout treatment, from initially asking the client to the one-year agreement, to obtaining commitment with a specific homework assignment. In the case study at the end of this chapter, commitment strategies are used extensively with April to change some of her destructive patterns because she sees these problems created primarily by others rather than herself.

DBT counselors have a wide variety of strategies for increasing client commitment, selecting the best fit for a particular client in a given situation:

1. *Pros and Cons:* The counselor has the client identify the pros of committing to a particular behavior or solution as well as the cons, which are likely to come to the client's mind after session.
2. *Devil's Advocate:* The counselor plays devil's advocate to offer counterarguments that are *slightly weaker* than the client's commitment to change.
3. *Foot-in-the-door/Door-in-the-face Techniques:* The foot-in-the-door technique involves asking the client to commit to a relatively small commitment first (e.g., write an email) and then ask for something more (e.g., use a new interpersonal skill in an email). Reversing the order of easy-to-difficult tasks, door-in-the-face techniques involve asking for something big (e.g., commitment not to cut) then something easier (e.g., call me before you do). Depending on the specific behavior to be targeted and the particular client's psychology, one or the other may be used.
4. *Connect to Prior Commitments:* Sometimes reminding clients of prior commitments is a way to help them commit to a particular action, especially in crisis situations. For example, a DBT counselor may remind a client who is thinking about cutting that she made a commitment to not hurt oneself at the start of treatment, or that she reported a commitment she made with herself to not allow her children to know she cuts.
5. *Highlight Freedom to Choose and Absence of Alternatives:* In some cases, it is helpful to highlight that the client has the freedom to choose whether or not to try a new behavior or solution, but by choosing to not change a problem behavior, certain undesirable consequences follow: "You can, of course, *choose* to not use the interpersonal skills we have learned in your relationship with your boyfriend, but chances are you are going to continue to have the same problems you've been having all along. The very problems you say are intolerable and make you cut. You are free to choose whether to continue having the same painful interactions or to try something new. Either way, I think it is important that you consciously make your choice."
6. *Principles of Shaping:* In some cases, DBT counselors use classic principles of shaping from behaviorism (see Chapter 9). In such situations, the counselors asks for a series of small steps to achieve a goal, such as first agreeing to reduce the frequency

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or severity of self-harm, and then gradually adding other steps to reduce the harm until the behavior is replaced by a more effective coping strategy.
7. *Cheerleading:* Some times commitment is promoted by using cheerleading strategies to generate hope.
8. *Agreeing on Homework:* When working on behavioral skills or problem solving, the counselor may solicit a specific agreement about homework. In such cases, Linehan (1993a) recommends writing down the homework tasks for the client and making sure the counselor follows up in the next session.

Self-Monitoring: Diary Card

DBT may ask clients to fill out a *diary card* between sessions to promote self-monitoring (Koerner, 2012). A diary card asks clients to rate the frequency and intensity of behaviors targeted for change, including suicidal thoughts, self-harm, and substance use. In addition, the card allows clients to record how often they used each of 23 skills taught in the skills group program. This card is presented at the beginning of each individual session for the clinician to quickly assess events of the past week, including crisis behaviors. The information on the card should always be directly discussed with the client to convey the importance and value of self-monitoring; this information is then used to structure and set the agency for the session. See Koerner (2012, pp. 86–87) or Safer et al. (2009, pp. 82–83) for samples of diary cards.

Contingency Management Procedures

Contingency management procedures are used to make all interactions between the client and counselor a learning opportunity. Each counselor response to the client is an opportunity to shape the client's subsequent behaviors, thoughts, and feelings (Linehan, 1993a). This process involves uses basic behavioral principles within the therapeutic relationship to reinforce behaviors targeted by goals, and to extinguish those that are not. Before using these, the counselor explicitly explains to the client how learning and reinforcement work. Contingent management involves the following:

1. *Reinforcing goal-related adaptive behaviors:* Using *immediate* reinforcement as often as possible, the counselor is quick to positively reinforce goal-related adaptive behaviors with expressions of approval, interest, or attention.
2. *Extinguishing target-relevant maladaptive behaviors:* When clients exhibit behaviors that are maladaptive specific to stated goals (e.g., threatening suicide when not getting what she wants), the counselor must identify what response is reinforcing the maladaptive behavior and extinguish it (e.g., backing off of a limit). Although simple in concept, this can be extremely difficult in practice, especially with suicidal clients. Thus, it is often helpful to find another response to positively reinforce (e.g., recognizing that the client is responding better to the limit in some way) or to help soothe the client (e.g., "I know this is difficult right now because you were hoping I would…").
3. *Correction-Overcorrection as Aversive Consequence:* In response to a problem behavior, the counselor not only uses aversive consequence to correct a given behavior (e.g., natural consequence) but also adds an overcorrection (e.g., goes beyond the initial damage to in some way add something positive to the situation). For example, if a client does not do her skills homework, a natural consequence would be asking her to do it again along with another task for the given week; the overcorrection would be spending group time doing a behavioral analysis of why she did not do her homework, and a solution analysis as to how she can get tasks for the past and upcoming week done.

Observing Limits Procedures

A specific application of contingency management, *observing limits procedures* are used to enable the counselor to appropriately set and maintain limits with clients (Linehan, 1993a). Such limits may include not extending a session if the client runs late, not accepting calls on a home phone line, or not sharing certain types of personal information. The counselor is responsible for maintaining these limits, not the client.

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Furthermore, each counselor is responsible for identifying his/her own personal limits and communicating these clearly with clients. Observing limits procedures include:

1. *Monitoring limits:* Counselors need to monitor their interactions with clients, as well as their internal responses, to clearly identify when limits are being crossed to avoid a sudden change in the counselor's attitude.
2. *Being honest about limits:* Counselor limits are for the good of the counselor, not the client, and the counselor should be honest about this with clients.
3. *Temporarily extended limits when necessary:* In certain situations and crisis moments, a counselor may need to consider extending or softening his/her limits but should do so by clearly communing the exception to clients.
4. *Being consistently firm:* If a limit has been set, the counselor needs to be consistently firm in maintaining it; inconsistent reinforcement will only strengthen the undesired behavior.
5. *Combining soothing, validating, and problem solving with observing limits:* When setting limits, the counselor is not giving clients what they want or think they are entitled to. Thus, the process also requires soothing, validating, and/or problem solving to help the client cope with the experience of having a limit set.

Family Interventions

Several practitioners have begun using family interventions as part of DBT. Families have been incorporated as part of multifamily DBT skills groups designed to introduce families to DBT skills and educate families about the importance of validation (Fruzzetti, Santisteban, & Hoffman, 2007). Because many clients have experienced invalidating environments in the past, helping families to effectively provide validation can significantly improve relationships at home and improve the identified client's ability to self-regulate. The modules of the multifamily groups include:

- Education about borderline personality disorder
- Relationship mindfulness and emotional self-management
- Family environments
- Validation
- Problem management

When working with adolescents who self-harm, family sessions are often added to the treatment plan (Miller et al., 2007). In the first session with a family, a family crisis plan is typically developed. Subsequent sessions may focus on family behavioral analysis of both adaptive and maladaptive responses. If a particular family member is a source of conflict, then this particular relational dynamic would be addressed. In addition, specific contingencies for problematic behavior, similar to the contingencies used by the DBT practitioner in session, may be developed.

Putting It All Together: Cognitive-Behavioral Case Conceptualization and Treatment Plan Templates

Theory-Specific Case Conceptualization: Dialectical Behavior Therapy

Use the prompts below to develop a theory-specific case conceptualization; the case study at the end of the chapter provides an example.

Suicidal and Self-Harming Behaviors

Assess current and past suicidal or self-harming behaviors.

Therapy-Interfering Behaviors

Generally assessed as counseling progresses, therapy-interfering behaviors include missing sessions, coming consistently late, not participating, and such.

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Quality-of-Life-Interfering Behaviors

Identify any quality-of-life-interfering behaviors such as:

- Substance and alcohol abuse
- Risky sexual behavior
- Criminal and illegal behaviors
- Extreme financial difficulties
- Severely problematic and/or abusive interpersonal relationships
- Occupational or school-related problematic behavior
- Health and illness-related problematic behavior
- Housing-related problematic behavior
- Mental health-related problematic behavior patterns

Invalidating Environments

Assess for past and current invalidating environments, including:

- Family of origin
- Current and adult intimate relationships
- Friendships or social groups, including online communities
- Work/school context

Trauma History and Marginalization

Assess for childhood or adult trauma as well as experiences of sexism, racism, and so on, including:

- Childhood sexual, physical, and/or emotional abuse and neglect
- Adult relationships that include physical, emotional, or sexual abuse
- Marginalization due to gender, race, ethnicity, sexual orientation, and others

Behavior Chain Analysis

Specific problem behaviors can be identified and analyzed to identify reinforcers.

Problem behavior: Briefly define behaviorally

Step-by-step description of chain of events related to problem: Describe chain of events leading up to and including the problem behavior and its aftereffects, including:

- Physical or other vulnerabilities prior to episode
- Events leading up to episode
- Step-by-step description of the problem behavior
- Consequences of the problem behavior, including physiological, emotional, cognitive, behavioral, and relational

Treatment Plan Template: Dialectical Behavior Therapy

This is a sample plan for use with individual clients diagnosed with borderline personality disorder.

Treatment Plan

Initial Phase of Treatment

Initial Phase Therapeutic Tasks

1. *Develop working counseling relationship. Diversity consideration:* [Describe how you will be setting limits and boundaries, consider client norms based on ethnicity, gender, age, and so on.]
   Relationship building interventions:
   a. Balance **nurturing** and **acceptance** of the client with **benevolent demands** for **change**.

(*continued*)

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   b. Use **validation** to increase client comfort with **commitment to** treatment.
   c. Develop a clear **client agreement** that outlines the length of treatment, terms of treatment, and handling of crisis situations; also include a **practitioner agreement** that describes what the counselor agrees to do.

2. *Assess individual, systemic, and broader cultural dynamics. Diversity considerations:* Consider cultural, gender, socioeconomic, sexual orientation norms when assessing client system as well as history of marginalization.
   Assessment Strategies:
   a. Assess for history of **trauma** and **invalidating environments** as well as current **suicidal, therapy-interfering, and quality-of-life-interfering behaviors**.
   b. **Behavioral analysis** to identify how specific problem behaviors are reinforced.

Initial Phase Client Goals

1. *Decrease* **suicidal and/or self-harming behaviors** to reduce sense of hopelessness and feeling overwhelmed.
   Interventions:
   a. **Commitment strategies** to motivate client to stop/reduce self-harm or suicidal behaviors.
   b. **Behavioral chain analysis** to identify behavioral reinforcers.
   c. **Solution analysis** to identify alternative adaptive behaviors to managing feeling overwhelmed and/or hopeless.

2. *Decrease* [specify **quality-of-life-interfering and/or therapy-interfering behaviors**] to reduce lability.
   a. **Behavioral analysis** and **insight analysis** to identify behavioral reinforcers of problem behavior.
   b. **Commitment strategies** to motivate client to reduce or stop problem behaviors.
   c. **Solution analysis** to identify alternative behaviors.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* [Describe how you will ensure that limits are appropriate for client's age, gender, cultural background, etc.]
   Assessment Intervention:
   a. Use **validation** to acknowledge difficulties might be having with client–counselor relationship.

Working Phase Client Goals

1. Increase client's ability to **regulate emotions** to reduce labile affect and impulsive behavior.
   Interventions:
   a. Use **emotional validation** to help client recognize and expression emotions.
   b. Support client in practicing **emotional regulation skills**, such as labeling emotions, challenging myths, reducing negative emotions, and increasing positive emotions.
   c. Combine **behavioral analysis, insight strategies, and solution analysis** to identify more adaptive responses to stress.
   d. Encourage use of **wise mind** to help client balance emotions and intellect.

2. *Increase* **interpersonal effectiveness** in personal and work relationships to reduce interpersonal conflict.
   Interventions:
   a. Use **emotional, cognitive, and behavioral validation** to help client understand how she experiences and behaves in relationships and to feel that these are understandable to another.

(*continued*)

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b. Support client in using **interpersonal effectiveness skills**, such as challenging myths, using low-intensity requests, and practicing skills in community.
c. Combine **behavioral analysis**, **insight strategies, and solution analysis** to help client identify more adaptive strategies for relating to others.
d. Use **contingency management** and **limit setting** within the counseling relationship to practice interpersonal skills.

3. Increase **distress tolerance** and ability to accept "what is" to reduce crisis behaviors and emotional lability.
Interventions:
a. Use **emotional, cognitive and behavioral validation** to help client feel that thoughts, feelings, and behaviors related to distressing situations are understandable.
b. Encourage client to use **distress tolerance skills**, such as self-soothing, distraction, and mindful breathing.
c. Use **solution analysis and wise mind** to help client find appropriate responses in distressing situations.

Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity considerations:* Include individual, family, and community resources as supports, such as religious and ethnic community groups.
Intervention:
a. Identify specific **relationships**, **support groups**, **and favorite skill exercises** that client can use post-termination to maintain gains.

Closing Phase Client Goals

1. *Increase* sense of resolution regarding past **trauma** [and/or experience of discrimination] to reduce [specify trauma-related symptoms].
Interventions:
a. Use **emotional**, **behavioral**, **and cognitive validation** to help client feel validated regarding experience(s) of past trauma [and/or discrimination].
b. Use **insight strategies** to help client make sense of trauma memories and narrative.
c. **Solution analysis** to identify alternatives to specific trauma symptoms.
d. Encourage use of **wise mind** to help client make sense of past traumas.

2. *Increase* **self-respect** and ability to **pursue goals** to reduce sense of worthlessness and hopelessness.
Interventions:
a. **Validate** client goals and aspirations while simultaneously helping client learn to **self-validate** when appropriate.
b. **Solution analysis** to help client identify adaptive strategies to achieve personal goals.
c. **Insight strategies** to help client develop self-respect and self-compassion.

Trauma-Focused Cognitive Behavioral Therapy

In a Nutshell: The Least You Need to Know

Trauma-focused cognitive-behavioral therapy (TF-CBT) (Cohen, Mannarino, & Deblinger, 2006, 2012) is an evidenced-based approach for working with children and adolescents who have experienced traumatic events, such as sexual abuse, death of a parent, or

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natural disaster. The model is designed to be short-term and strength-based, with the ultimate goal not only to resolve trauma but also to increase the child and family's sense of self-efficacy. The program is comprised of ten components, which can be individually tailored to meet a particular client's needs. As the name implies, the program is based in cognitive-behavioral therapy, and also integrates elements of family systems theory (Chapter 11), humanistic approaches (Chapter 6), and child development theory. The model begins with psychoeducation about trauma for the child and parents, as well as parent training to help the primary caregivers support the child at home. Later elements include relaxation training, affective expression and modulation, cognitive coping, trauma narrative, *in vivo* mastery, and future safety. TF-CBT has been widely adopted by government and state agencies to provide improved treatment of trauma to children and adolescents (Sigel, Benton, Lynch, & Kramer, 2013; Sigel, Kramer, Conners-Burrow, Church, Worley, & Mitrani, 2013). Finally, a free ten-hour introductory course is available online to professionals to provide initial training in this evidence-based approach (www.tfcbt.musc.edu).

The Juice: Significant Contributions to the Field

If you remember one thing from this chapter, it should be …

Trauma Narrative

Creation of the trauma narrative is the signature intervention in TF-CBT and is introduced only after a foundation of psychoeducation, relaxation, and cognitive coping has been established (Cohen et al., 2006, 2012; Smith & Saunders, 2005). The trauma narrative is considered a *gradual exposure technique* designed to unpair thoughts and memories of the trauma from overwhelming emotions. A trauma narrative includes not only verbal sharing of the story but also a written account. Clinically, the intervention helps to:

- Reduce intrusive and upsetting trauma imagery, such as flashbacks and nightmares
- Reduce avoidance of trauma cues and emotions
- Identify unhelpful thoughts and beliefs related to the trauma
- Help the child prepare for and anticipate reminders of the abuse

Over the years, research increasingly indicates that trauma narratives are essential to help traumatized adults and children integrate thoughts and feelings about the trauma, with some suggesting it actually helps the brain return to healthier neural states (Siegel, 2010). The trauma narrative is built upon several other core components of the treatment; thus, the details for how to create the narrative are covered in "The Doing" section below.

Rumor Has It: The People and Their Stories

Judith Cohen Judith Cohen, a board-certified child and adolescent psychiatrist, is the medical director of the Center for Traumatic Stress in Children and Adolescents, which is part of the Allegheny General Hospital in Pittsburgh. Judith Cohen and Anthony Mannarino began their joint research on trauma treatment for children and adolescents in the 1980s, initially focusing on children who had been sexually abused. Their research became the foundation for TF-CBT. She is widely regarded in the area of diagnosing and treating posttraumatic stress disorder in children and adolescents and is the associate editor of the *Journal of Traumatic Studies*.

Anthony Mannarino Anthony Mannarino, a licensed clinical psychologist, is the director of the Center for Traumatic Stress in Children and Adolescents, working with Judith Cohen since the early 1980s on the treatment of traumatized children, with their joint work culminating in the development of TF-CBT. He is widely regarded as an expert on childhood traumatic stress and grief, having won numerous federal grants and numerous honors for his research. He serves as chair of the department of psychiatry at the Allegheny General Hospital in Pittsburgh and is a professor of psychiatry at Drexel University College of Medicine.

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Esther Deblinger Ester Deblinger, a professor of psychiatry at the University of Medicine and Dentistry of New Jersey, is the codirector of the Child Abuse Research Education and Service Institute. She conducted several independent randomized clinical trials with children who have experienced trauma before joining with Drs. Cohen and Mannarino to develop the TF-CBT model. She was one of the first to develop interventions using trauma narratives.

Big Picture: Overview of Counseling Process

Core Values

The foundation of the TF-CBT counseling process is summarized in the *core values* (Cohen et al, 2006, 2012):

- *Components-Based:* The approach is comprised of ten components, which build upon each other and are readily adapted to meet the needs of a particular child and family.
- *Respectful of Diversity:* Individual, family, community, cultural, and religious beliefs and values are considered, both when assessing the impact of a traumatic event and when supporting the family in healing from the trauma.
- *Adaptable:* Flexibility and creativity are essential to successfully implementing the ten components of TF-CBT.
- *Family-Focused:* Although it is a treatment for children, the parents and family are closely involved with the treatment process; research has found this is particularly important for treating externalizing behaviors, such as tantrums and defiance (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011).
- *Therapeutic Relationship-Centered:* A safe and trusting therapeutic relationship is essential for children and their families to heal from trauma.
- *Self-Efficacy-Focused*: In addition to resolving trauma symptoms, TF-CBT aims to increase the child and family's sense of self-efficacy, and to promote resiliency and long-term wellness.

Treatment Structure and Components

TF-CBT is an approach that begins initially with individual sessions for both the child and the family, and it increasingly moves toward conjoint family sessions (Cohen et al., 2012). However, if a child has significant behavior problems, conjoint sessions will be used earlier to provide additional support, for the parents to learn parenting skills and for the child to learn coping skills. Parent involvement is considered key to positive outcomes.

Although the approach is flexible and can be individually tailored, typically the counselor works through the ten components of TF-CBT in sequential order, because each builds upon the prior. The ten components are generally used with all children suffering from trauma, regardless of the form of trauma. However, certain components may be more relevant than others to a particular child and family, and counselors may adapt as needed to best serve client needs. Furthermore, once a particular component has been introduced, it is typical to revisit it again in conjunction with other components or in response to new developments. In situations where the trauma is ongoing, such as in some domestic violence situations, enhancing safety and parenting engagement are generally addressed earlier in treatment; additionally, the process of working through the trauma narrative is adapted to account for the ongoing trauma (Cohen, Mannarino, & Murray, 2011).

The ten components of TF-CBT are:

1. Psychoeducation on TF-CBT
2. Parenting skills
3. Relaxation
4. Affective expression and modulation
5. Cognitive coping and processing I

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6. Trauma narrative
7. Cognitive coping and processing II
8. *In vivo* mastery
9. Conjoint child-parent sessions
10. Enhancing future safety and development

TF-CBT Session Flow

Although TF-CBT is adapted to the needs of each client, treatment is typically provided in 12 weekly sessions that are 90 minutes long or 16–20 weekly sessions that are 60 minutes long (Hoch, 2009). When offered in 90-minute sessions, 45 minutes are spent with the nonoffending parent or caregiver and 45 minutes with the child, with conjoint time as necessary. Similarly, the 60-minute sessions are divided, with the time roughly evenly shared between parent and child. In the 90-minute model, the twelve sessions are generally divided as follows:

Sessions 1–4

- Psychoeducation and parenting skills
- Relaxation and stress management
- Affective expression and regulation
- Cognitive coping

Sessions 5–8

- Trauma narrative development and processing
- *In vivo* gradual exposure

Sessions 9–12

- Conjoint parent-child session
- Enhancing future safety and development

Phase-Oriented Treatment

When working with traumatic grief, TF-CBT addresses trauma symptoms first and then moves on to grief (Cohen et al., 2006). This is particularly critical if the child has certain types of traumatic symptoms, such as flashbacks of the body or death. Furthermore, since many children will have avoidance trauma symptoms, they may not be sufficiently in touch with their feelings to effectively engage in grief work. Although the treatment of trauma and grief are conceptualized as two separate phases, some children will naturally move back and forth between the two, depending on which issue is more prominent at a given time.

Making Connection: Counseling Relationship

Centrality of the Counseling Relationship

The counseling relationship is considered central to TF-CBT because traumatized children—by definition—have had experiences that result in a loss of a sense of safety and trust (Cohen et al., 2006). For those experiencing sexual abuse or other forms of interpersonal violence, trusting another adult can be particularly difficult. Thus, the counseling relationship must first and foremost be a safe, nurturing, accepting, and reliable relationship for traumatized children. Similarly, parents of children who have been traumatized have either been directly (e.g., the parent was also abused by the perpetrator) or indirectly (e.g., learning their child was abused) traumatized themselves. In some cases, the child does not turn to the parent for support, either because the parent was traumatized him/herself or because the child fears burdening the parent. In such cases, the counselor serves as a model of safety and support until the counselor is able to help return the parent to the primary support role in the child's life.

Cohen et al. (2006) emphasize the importance of staying emotionally attuned to clients rather than becoming overly focused on the various tasks and components of

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TF-CBT. They recommend counselors employ a humanistic relationship (Chapter 6) with clients that includes:

- Focused listening
- Attending to nonverbal communication
- Reflective listening
- Accurate empathy
- Being genuine and "real"
- Responding to overt and latent messages

Clinical Judgment

Although this is a manualized treatment with specified components, *clinical judgment* is central to adapting the model to meet an individual client's need (Cohen et al., 2006). Counselors who think they can (or fear they will be expected to) implement the model as an automaton, simply plodding through the components one after another, will be disappointed (or, alternatively, relieved). On the contrary, treating traumatized children and their families requires the counselor to constantly reflect on an individual client's needs and how best to adapt the model. For example, if a child or teen is self-harming, this dangerous behavior should be addressed first. Similarly, the counselor needs to use not only the guidance provided by the model but also all prior training and knowledge to figure out how to best help a particular child end self-harming.

The Viewing: Case Conceptualization

Trauma Assessment

Defining Trauma As a treatment for children and adolescents who have been traumatized, *trauma assessment* is typically done in order to decide whether TF-CBT is an appropriate treatment intervention. Trauma differs from stress in several significant ways (Cohen et al., 2006). Unlike stress, which can be severe, trauma involves:

- Sudden or unexpected events
- Events that are shocking in nature
- Death or threat to life or bodily integrity
- Feelings of intense terror, horror, or helplessness

Common examples of childhood trauma include sexual/physical abuse, school shooting, major car accident, major medical procedures, war/terrorism, natural disaster, or sudden death of a loved one. In contrast, the stress of divorce or the death of an elderly loved one typically does not fit the criteria for trauma.

Resiliency and Trauma Not all children who are exposed to or who experience a traumatic event develop trauma symptoms or PTSD (Cohen et al., 2006). Approximately 22% of abused or neglected children demonstrate resiliency to the trauma, indicating that the vast majority of traumatized children would benefit from treatment (De Bellis & Zisk, 2014). Several *resiliency factors* seem to buffer against trauma, including the child's developmental level, inherent and/or learned resiliency qualities, supportive relationships, and/or other sources of support in a child's life. Thus, two children exposed to the same trauma may have very different responses, depending on their age, innate resilience, and the meaning they make of the trauma event. Generally, the younger the child, the more the child's ability to cope is positively correlated to the parent's ability to cope.

Diagnosis of PTSD The latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013) includes a new set of criteria for diagnosing posttraumatic stress disorder (PTSD) in children under six, and a revised set of criteria for older children and adults. The new criteria for children were adapted to facilitate more accurate assessment of trauma in young children, who often express trauma through play or

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other nonverbal expressions. Both sets of the new diagnostic criteria have reorganized trauma symptoms into four types of symptoms:

- *Intrusive symptoms:* Memories or dreams related to the event that cause psychological distress and/or physiological reactions.
- *Avoidance symptoms:* Avoidance of distressing thoughts, memories, feelings, and/or external reminders of the traumatic event.
- *Negative alterations in cognitions and mood:* Inability to remember elements of trauma, negative beliefs resulting from the trauma, distorted cognitions related to the cause or consequences of trauma, persistent negative mood states, and such.
- *Alterations in arousal and reactivity:* Irritable mood, reckless behavior, hypervigilance, exaggerated startle response, concentration difficulties, and/or sleep disturbance.

Assessment of PTSD is often made by a nonstandardized diagnostic interview by the clinician. If formal assessment is used, Cohen et al. (2006) recommend using either:

- UCLA PTSD Reaction Index
- Traumatic Events Screening Inventory—Child Version

Complex Trauma Sometimes children or adolescents exposed to trauma develop what is called *complex trauma*, which is characterized by pervasive difficulties in multiple areas of life functioning and are generally associated with chronic, interpersonal childhood traumas, such as ongoing sexual abuse (Cohen et al., 2006; Cohen, Mannarino, Kliethermes, & Murray, 2012; Wamser-Nanney & Vandenberg, 2013). These children often develop severe mood instability, highly conflictual relationships, poor self-esteem, self-harming behaviors, substance abuse issues, and academic issues. TF-CBT has been used with adolescents who would qualify as having complex trauma, although researchers are still exploring how best to meet the needs of these clients. TF-CBT is adapted to complex trauma by spending more time in the coping skills phase, implementing the safety component earlier and as necessary throughout, slower introduction of gradual exposure, and tracing trauma themes across incidents (Cohen et al., 2012).

Trauma and the Brain Increasingly, the researchers are studying the physiological effects of psychological trauma on children (Cohen et al., 2006; De Bellis & Zisk, 2014; Rinne-Albers, van der Wee, Lamers-Winkelman, & Vermeiren, 2013; Siegel, 2010). Although much is still unknown as to how the brain is affected by childhood trauma, research has identified some of the following patterns. Traumatized children tend to have:

- Higher resting pulse and blood pressure
- Greater physical tension
- Hypervigilance
- Smaller intracranial volume (brain size)
- Lower intelligence quotients (IQs)
- Smaller corpus collosi
- Impaired neural integration, an optimal state of brain functioning
- Difficulty integrating implicit and explicit memory related to the trauma

Assessing for Comorbid Disorders Because other psychiatric conditions are also present in children diagnosed with PTSD, traumatized children should also be assessed for (Cohen et al., 2006):

- Depression
- Suicidality and self-harm
- Psychosis
- Substance abuse
- Conduct disorder

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Traumatic Grief Assessment

Traumatic grief refers to the unexpected and/or violent death of a loved one (Cohen et al., 2006). Examples of traumatic death include losing a loved one to violence, accident, suicide, natural disaster, acts of terrorism, or being the first to find the body of the deceased. Traumatic grief is a form of *complicated grief*, which is distinguished from *normal or uncomplicated grief processes* by symptoms of a) separation distress and b) trauma. In TF-CBT, children who have experienced traumatic grief are treated both for trauma and grief with separate components. Typically, the trauma symptoms are treated first and the grief second, although this may vary depending on the particular child's presentation of symptoms. To assess for childhood traumatic grief, Cohen et al. (2006) use the following criteria:

1. A loved one died under circumstances the child considers traumatic or horrifying
2. Significant PTSD symptoms related to the traumatic cause of death
3. PTSD symptoms impinge on child's ability to effectively grieve

Child Trauma Symptoms

When assessing traumatized children, TF-CBT counselors assess the following areas of functioning, which are later targeted in the treatment plan (Cohen et al., 2012). The acronym for assessing child functioning is CRAFTS:

- *Cognitive functioning:* Dysfunctional thought patterns, learning problems, or concentration difficulties
- *Relational functioning:* Increased conflicts with friends or family, avoiding friends or family, or impaired trust in interpersonal relationships
- *Affective functioning:* Difficulty expressing emotions and/or managing feelings of anxiety, depression, or anger
- *Family/Caretaker problems:* Parenting difficulties, parent-child conflict, difficulties with extended families, foster home placements, and such.
- *Traumatic behavior:* Avoidance symptoms, sexual acting out, aggression, and/or noncompliance
- *Somatic symptoms:* Sleep problems, hyperarousal, headaches, stomachaches, or other physical reactions to traumatic memories or triggers

Child Functioning Prior to Trauma and Strengths

Whenever possible, TF-CBT practitioners try to obtain a good history of the child's functioning prior to the trauma, which provides a baseline for coping and temperament (Cohen et al., 2006). In addition, assessing prior functioning can help identify the child's strengths and areas of resilience. When assessing prior functioning and strengths, the counselor inquires about the child's prior:

- Temperament
- Coping skills
- Preexisting psychological issues
- Strengths and interests

Once these are identified, the TF-CBT counselor can better assess current strengths, areas of resilience, and adaptive functioning, which may be academic, extracurricular, social, emotional, behavioral, or relational. For example, a child may have trauma symptoms that are problematic mostly at home but may continue to function well at school, on a soccer team, or with friends.

Baseline Narrative

TF-CBT practitioners ask children to provide a narrative of positive life experience to prepare them for discussing the trauma narrative, which is a key component of the approach (Cohen et al., 2006). Researchers have found that when children were asked

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to share a positive or neutral narrative before sharing the abuse narrative, they were better able to provide a more detailed and coherent narrative. Thus, asking for the narrative of a positive experience provides a baseline for work with the trauma narrative, while also building rapport and identifying strengths. As part of this narrative, children are asked to describe their feelings, thoughts, and physical sensations. This assessment may reveal that they have a limited vocabulary for identifying feelings, which can then be used to inform treatment planning. After providing a narrative about a positive event, the interviewer then asks a similar set of questions about the traumatic event to assess client's level of avoidance and coping skills.

Sample Baseline Narrative Questions

Initial Prompt for Positive Event: "I'm really enjoying getting to know you, and I wondered if you would tell me about an activity you participated in recently that you really enjoyed. Can you tell me about a favorite activity or a party you went to recently that you enjoyed?" (Cohen et al., 2006, p. 25).

Child Response: Try to allow the child to give a spontaneous response. Use open-ended prompts such as the ones below to facilitate if necessary:

Follow-up Questions for the Positive Event

- Can you describe some of the thoughts that ran through your head [during the activity]?
- Can you describe how you felt during this activity?
- Can you describe the physical sensations of doing this activity?
- What happened next?
- Can you tell me more about [identify a specific detail]?

Trauma Narrative Prompt: "You did such a good job telling me all about what happened at the birthday party. Now I'd like you to tell me about everything that happened on the day the police came to your house. Would you like to tell me about what was happening before the police came or what happened after the police came to you house?" (p. 26).

Follow-up for Initial Sharing of Trauma Narrative: The focus should be on building a context of safety rather than pushing for details. If the child seems comfortable and it seems clinically appropriate, follow-up questions similar to the ones above may be used. However, in many cases broad, open-ended questions that facilitate the telling of the basic narrative are all that are needed.

Praise: The child should be praised for sharing whatever he/she is able to share related to the trauma.

Try It Yourself

Find a partner and role-play the assessment of the baseline narrative and trauma narrative. You can either role-play being a child or use real personal events.

Standardized Testing

TF-CBT practitioners may also choose to use standardized tests to assess for PTSD or related disorders, such as depression. Cohen et al. (2012) recommend the following instruments:

- Schedule for Affective Disorders and Schizophrenia for School-Aged Children: Present and Lifetime Version
- UCLA PTSD Reaction Index
- Children's Depression Inventory
- Child Behavior Checklist

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- Strengths and Difficulties Question
- Multidimensional Anxiety Scale
- State-Trait Anxiety Inventory for Children
- Shame Scale

Parental Functioning

Parental functioning is also critical to assess: both as it is related to the trauma and overall (Cohen et al., 2012). Research indicates that the parent's level of distress related to the trauma significantly influences that of the child's, especially for younger children. Specifically, counselors should assess each parent or caregiver's a) response to the trauma and b) coping style.

Based on this assessment, the counselor may refer parents for their own personal treatment, in addition to participating in the family components of TF-CBT. Specific measures can be used to help assess parental response to the child's trauma, parenting skills, and general functioning; these include:

- Impact of Event Scale—Revised
- Parent Emotional Reaction Questionnaire
- Beck Depression Inventory
- Parenting Practices Questionnaire
- Alabama Parenting Questionnaire

Targeting Change: Goal Setting

Optimize Adaptive Functioning

The overarching goal of TF-CBT is to increase self-efficacy and optimize the child's adaptive functioning in all areas of life: family, friends, school, physical health, and emotional health (Cohen et al., 2006; Hoch, 2009). Depending on the child and situation, potential goals may include:

Initial Phase Goals

- Reduce intrusive thoughts and memories
- Reduce avoidance symptoms
- Reduce self-harm, substance abuse, or other high-risk behavior
- Increase child's ability to self-soothe
- Increase parental effectiveness with limit setting

Working Phase Goals

- Increase child's ability to effectively express and modulate emotions.
- Increase tolerance of memories of trauma without triggering overwhelming emotions or reactions.
- Decrease inaccurate or unhelpful thoughts related to trauma.
- Increase positive interactions with family and/or peers.

Closing Phase

- Increase sense of child's present and future safety
- Increase/restore emotional bond between parent and child
- Increase sense of adaptive acceptance related to loss
- Develop positive redefined relationship with the deceased

The Doing: Interventions

Psychoeducation

The first component of TF-CBT is psychoeducation, which begins with the initial phone call and continues throughout treatment (Cohen et al., 2006, 2012; Smith & Saunders, 2005). The purposes of psychoeducation include a) normalizing the child's and family's responses to trauma, b) developing realistic expectations, beliefs, and cognitions about trauma and its treatment, and c) inspiring hope for recovery. Psychoeducation is

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provided to the child and parents based on the type of trauma experienced, the age of the child, and types of symptoms experienced. Psychoeducation can be a powerful intervention to reduce anxiety and stress and effectively engage both parents and children in the treatment process.

Psychoeducation in the Initial Phone Call

- Normalize trauma symptoms, child's response, and parent's concerns
- Positive prognosis for trauma: most children who receive treatment do get better and recover (Cohen et al., 2006)

Psychoeducation During Initial Assessment and Early Sessions

- *General education about abuse and trauma:* Age-appropriate education about trauma to normalize child and family reactions.
- *Trauma-specific education:* Next, specific information about the particular type of trauma is provided; separate handouts for adults and children who have experienced domestic violence and sexual abuse are available in Cohen et al., 2006.
- *Overview of TF-CBT treatment:* The practitioner provides an age-appropriate overview of the approach, its philosophical foundations, research base, and components. This helps build trust in the treatment process and a sense of hope for recovery.
- *Role of parents:* Education is also provided about the role of parents in the recovery of childhood trauma, as well as their role in the TF-CBT process itself.
- *Risk reduction:* Finally, the counselor provides information about how to reduce future trauma.
- *Sex education (if appropriate):* For children who experienced sexual abuse, sex education may also be provided, as is age-appropriate and with parental permission. The counselor provides information about healthy sexuality, body awareness, boundaries, and health-related issues.
- *Grief (if appropriate):* When children have experienced traumatic grief, the counselor may also provide an overview of the grief process.

Parenting Skills Training

Parenting skills is the second component of the treatment, because research consistently indicates that successful recovery from childhood trauma is greatly facilitated by effective parental involvement (Cohen et al., 2006, 2012; Smith & Saunders, 2005). In addition to the psychoeducation about trauma and PTSD listed above, parenting skills training typically addresses the following themes:

- *Safety:* Helping parents find effective ways to help their traumatized children feel safe at home, school, and in the community. This may involve developing new rituals, routines, or structures that focus on specific fears the child may have (e.g., installing locks on a window or door).
- *Praise Desired Behaviors:* Parents are encouraged to use praise and positive attention as much as possible to encourage desired behaviors and reduce negative behaviors. Using in-session role-plays, parents are encouraged to praise using the following guidelines:
  - Praise a *specific behavior* (e.g., You did a great job setting the table the first time I asked) rather than praise globally (e.g., you are a really good girl).
  - Provide *immediate* praise whenever possible.
  - Be *consistent* with praise, especially when reinforcing new behaviors.
  - Avoid the temptation to add criticism after praise (e.g., "You are sharing so nicely with your sister today; why couldn't you do that yesterday when I really needed you to at the doctor's office?").
  - Emotional intensity should be offered at the same level as criticism would be.
- *Selective Attention for Negative Behaviors:* When appropriate, the parent is encouraged to use *selective attention* to avoid inadvertently reinforcing negative behaviors, especially if the child seems to get some emotional needs for connection met through negative attention. Selective attention involves ignoring or not

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responding to negative behaviors, which can be done by calmly focusing on another activity or walking away peacefully. Behaviors that might respond well to selective attention include:
  - Tantrums or angry outbursts
  - Hostile faces, eye rolling, etc.
  - Mocking the parent
  - Intentionally annoying comments
- *Time-Outs:* Another approach parents are taught for dealing with negative behaviors is a structured time-out. The purpose of the time-out is to interrupt the negative behavior and allow the child time to calm down and regain a sense of equilibrium. The following procedures are used for the time-outs:

Time-out Procedures

- **Calm Warning:** Before the time-out, the parent should make one calm request for the desired behavior, e.g., "please sit in your chair during dinner"; up to one more reminder may be added.
- **Calm Escort:** If the child does not head the warnings, the parent quietly escorts the child to the designated time-out spot.
- **Place:** The time-out spot should be a calm, quiet place without distractions. For some adolescents, their room—although filled with distractions—may still be an effective place for them to calm down, which is the ultimate goal.
- **Length:** 1 minute per year of age, e.g., 4 minutes for a 4-year-old.
- **Managing Behavior During Timeout:** If the child acts up during the time-out, additional minutes are added to the time-out.
- **Positive Ending:** After the time is over, the parent begins to act positive with the child to communicate that positive behavior results in positive attention. Typically, there is little or no need for discussion about the incident; negative lectures should be avoided.

Phelen (2010) provides a more detailed description for using time-outs with children 2–12.

- *Contingency Reinforcement:* Behavioral charts that reinforce desired behaviors or reduce problem behaviors may also be used.

Relaxation Techniques

Early in treatment, children are taught two basic relaxation techniques: focused breathing and progressive muscle relaxation (Cohen et al., 2006; Smith & Saunders, 2005). The purpose of teaching relaxation is to help invoke the relaxation response, which is the physiological opposite of the stress response, the primary response involved in trauma. These techniques also begin to teach children that they have control over their bodies and even their minds. Children learn and practice the techniques in session and are asked to also practice them at home. Parents are taught the same relaxation techniques, with the dual purpose of helping the parents manage their own stress as well as enabling them to help their children with relaxation exercises at home.

Focused/Controlled Breathing/Meditation

1. *Rationale:* Explain that the breathing technique will help the child manage his/her anxiety.
2. *Demonstrate:* The counselor then demonstrates the different elements of the breathing exercise:
   - Place one hand on upper chest; one on belly. Have the child breathe deep enough to have the hand on the belly move up and down ("belly breathing").

(*continued*)

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- Then take controlled breaths, counting to 5 on the in-breath and 5 on the out-breath.
- If the child seems cognitively ready, add the element of trying to quiet the mind by focusing on the breath and quieting other thoughts.
- Alternatively, a relaxing word like "calm" can be used to quiet the mind.

3. *Practice in Session:* Then have the child demonstrate in session, allowing any questions to be answered. At the end of the session, the child may be invited to help the parent learn the skill so that the parent can assist with the homework tasks.
4. *Practice at Home:* The child is then instructed to practice at home twice a day for ten minutes. A practice log may be given to help the child and family monitor the homework.

Try It Yourself

Find a partner and role-play teaching controlled breathing.

Affect Expression and Modulation

Several classic behavioral and cognitive interventions are introduced to help children learn how to manage difficult feelings and learn to regulate their emotions (Cohen et al., 2006, 2012; Smith & Saunders, 2005). This process begins by helping children build their emotional vocabulary and progresses to interrupting negative cognitions that fuel negative emotions. The following techniques are used to help promote affect expression and modulation:

- *Feeling identification:* Children are taught to label, identify, and discuss a wide range of emotions using a number of possible techniques, such as charts, games, drawings, and whiteboard activities. The counselor also helps the child learn to rate the intensity of feelings and learn how to appropriately express them.
- *Thought Interruption:* Thought stopping may be taught to children who experience intrusive memories. Children are taught to stop an unwanted thought by saying "stop!" aloud or with a physically signal like a hand wave. Then, the child can replace the negative thought with a positive one.
- *Positive Self-Talk:* Children can be taught positive self-talk to help manage emotions. They can be encouraged to give themselves positive messages when they feel overwhelmed or stressed:
  - "I can get through this."
  - "Things are bad now, but people are here to help things get better."
  - "My parents still love me."
  - "Everything will be okay."
- *Problem Solving and Social Skills:* Children who are experiencing behavioral or social problems may benefit from problem solving or social skills training.
- *Play Applications:* When working with young children, play interventions are used to help teach affective expression and modulation (Drewes & Cavett, 2012). For example, a Gingerbread Person Feelings Map may be used to help discuss feelings and where the feelings are physiologically felt in the body. Similarly, Feelings Charades can be used to practice expressing positive and negative feelings.

Cognitive Triangle and Cognitive Coping

Grounded in classic cognitive therapy premises (see Chapter 9), TF-CBT counselors teach clients how to counter unproductive negative thoughts using the TF-CBT cognitive triangle—to illustrate how negative thoughts lead to negative emotions and behaviors

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(Cohen et al., 2006; Smith & Saunders, 2005). The cognitive triangle is also used to illustrate how changing one's negative cognition to a more realistic or helpful thought can then change one's emotions and behaviors. The cognitive triangle and related cognitive coping skills are taught in two phases: a) generically before introducing the trauma narrative, and b) again after the trauma narrative to address specific problematic cognitions related to the trauma (see Figure 10.2).

The main purpose is to help children (and their parents) learn to distinguish between thoughts and feelings, thereby enabling them to then go back and challenge unhelpful beliefs (Cohen et al., 2006). The counselor facilitates this process in the following ways:

- Introduce the distinction between thoughts and feelings.
- Introduce the cognitive triangle.
- Use several examples from the child's life to identify the thought and related feelings and behaviors.
- Revisit the triangles with negative thoughts and replace the negative thought with a more helpful or realistic one.

Cognitive Processing of the Trauma Narrative Once the trauma narrative is constructed, this technique can be used to challenge unhelpful cognitions that arise in the narrative, such as "It was all my fault" or "I should have known better." Cognitions commonly targeted in this phase include (see Figure 10.3):

- Shame or stigma
- Guilt and feelings of responsibility
- Nonadaptive mistrust of others
- Beliefs about the offender or trauma
- Nonadaptive feelings about one's body or personal safety

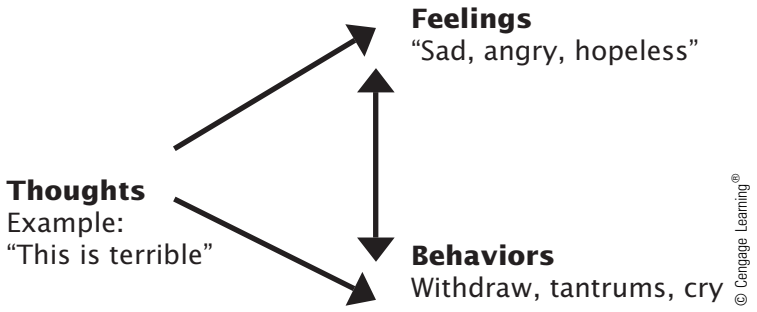

FIGURE **10.2.** Cognitive Triangle

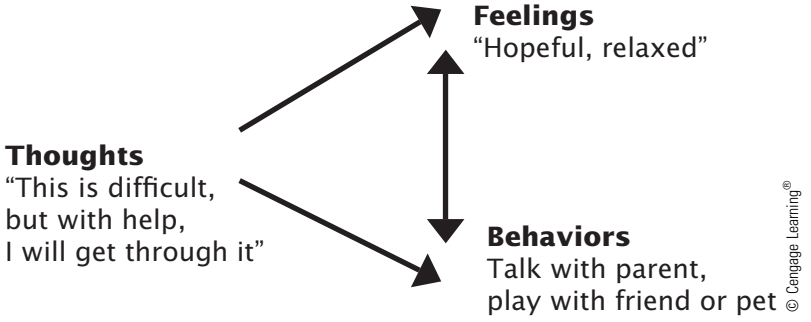

FIGURE **10.3.** Cognitive Triangle with More Accurate Thoughts

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Trauma Narrative

The trauma narrative is the primary intervention for targeting trauma symptoms in TF-CBT (Cohen et al., 2006, 2012; Smith & Saunders, 2005). As introduced in "The Juice" section above, the trauma narrative intervention is introduced once the child and parents have built a trusting relationship with the counselor, have more accurate understandings of trauma, and have developed relaxation and coping skills. These early components prepare the child and family for working on the trauma narrative, which is a gradual exposure technique. Essentially, the process involves the telling and written recording of the trauma, which is reviewed several times. Each time the narrative is reread, the experience provides another layer of exposure in a safe context, thereby unpairing the memory of the trauma from the overwhelming emotions and other trauma symptoms.

Overview of the Trauma Narrative Process

- *Introduce to Child and Parents:* The process of creating a trauma narrative should be discussed first with the child and parents. Any concerns that the parents may have should be directly addressed, including those related to legal proceedings or religious and cultural beliefs.
- *Select Format:* In addition to verbally sharing the story of the trauma, the child will be asked to create a written account, such as a book, picture, song, or poem, which can be done by hand, digitally, or a combination of both. When working with young children, the counselor should work with the child to find an appropriate play media, such as sand tray, puppets, or a dollhouse, to allow for telling the trauma narrative in an age-appropriate format; in these cases, the counselor can write down the narrative for the child (Cavett & Drewes, 2012).
- *Facilitate Sharing of Narrative:* Over the course of several sessions (typically), the counselor facilitates the sharing of the narrative, often beginning with a general description of the child (e.g., age, picture, family, etc.) and/or the day before the trauma occurred. Then the child verbally shares the narrative as the counselor facilitates verbalization of thoughts and feelings about events. The counselor then helps the child record the events in the selected format (e.g., draw pictures and write out the narrative).
- *Reading of Narrative:* If developmentally able, the child is asked to read each segment as it is completed; the counselor then asks the child to add any new thoughts or feelings that may emerge with the reading.
- *Worst Moment:* The child should be asked to include the "worst moment" of the trauma and include a picture and narrative of this moment, describing it in as much detail as possible.
- *Cognitive Challenging:* Only after the child has a full and complete written narrative does the counselor go back to challenge cognitive errors or distortions. Typically, the counselor will go back and reread the trauma narrative, stopping at points to address unhelpful beliefs or cognitions one by one; this challenging may involve role-plays of now-and-then or drawing a "responsibility pie," depicting who is responsible for how much.
- *Praise and Encouragement:* Throughout the trauma narrative process, the counselor offers praise and encouragement, including small rewards such as stickers or extra playtime.
- *Share with Parents:* When clinically appropriate, the counselor should facilitate the child's sharing the trauma narrative with the parent in one or more conjoint sessions.

In Vivo Mastery

If generalized fears remain after the trauma narrative has been worked through, behavioral *in vivo interventions* may be used to address these fears (Cohen et al., 2006). This intervention may be used when a child has fears that make it difficult to perform important life tasks, such as go to bed, go to school, or leave the house. Using classic behavioral strategies, the counselor develops a plan to carefully and slowly expose the child

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to the feared situation. The plan generally needs to be developed conjointly with parents. A typical plan may involve small steps that last for several days to a week each, such as a) playing in the bedroom during the day; b) playing in the bedroom at night; c) reading a bedtime story in the bedroom; d) sleeping in the room with a safe person, and e) sleeping in the room alone with a safety object.

Parent-Child Conjoint Sessions

The frequency of conjoint sessions can vary significantly, depending on the age of the child, type of trauma, availability of the parent, and the parent's own reaction to or experience of the trauma (Cohen et al., 2006; Smith & Saunders, 2005). Typically, the counselor, child, and parents decide together when and how to have family meetings. Typically, siblings are not involved in most of these meetings. The typical conjoint family session generally takes the following format, which is of course adjusted as needed:

- Counselor meets with individual child for 15 minutes
- Counselor meets with parent(s) for 15 minutes
- Counselor meets with parents and child together for 30 minutes

Recommendations for preparing for and conducting family sessions (Smith & Saunders, 2005) are as follows:

- *Assess the parent's readiness:* The parent needs to be emotionally ready and must have the ability to actively support the child. In some cases, the parents may need their own counseling before conjoint sessions can be productive.
- *Assess the child's readiness:* The child should be fairly comfortable discussing the trauma narrative with the counselor before sharing it with the parents.
- *Share the goals of the session:* The goal for a given conjoint session should be clearly identified to all participants (e.g., discuss a breathing homework exercise or review the trauma narrative).
- *Prepare the parent:* Parents should be prepared to give supportive comments to the child and to answer potentially difficult questions.
- *Content of the sessions:* Sessions addressing the trauma narrative should include the following three areas, which can be addressed in any order: a) sharing of the trauma narrative, b) personal safety issues, and c) areas of confusion or concern.
- *Ending the session:* Conjoint sessions should end on a positive note, such as sharing praise or appreciation, either related to the session or globally. Counselors should also provide explicit instructions for what or how to talk further about the trauma outside of session.

Enhancing Future Safety and Development

The last of the ten main components is enhancing future safety and development, which is particularly important for children who experienced abuse because they are at high risk for being revictimized (Cohen et al., 2006). The timing of addressing personal safety varies from child to child, but generally this is done after the trauma narrative has been processed. Children should be praised for what they did do to initially be safe, such as telling someone or trying to avoid a perpetrator. Counselors should be careful to not imply that the child should have done more to avoid the former abuse when discussing future safety techniques. Depending on the type of trauma experienced, addressing personal safety may involve instruction regarding:

- Basic knowledge about abuse and what constitutes abuse or inappropriate behavior from others, such as bullying
- Safe and appropriate touch
- Learning to identify "gut" reactions about safety
- Setting physical boundaries with peers and adults
- How to leave a potentially dangerous or uncomfortable situation
- Assertiveness training and role-plays
- Healthy conflict management
- How to contact assistance in an emergency

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In addition to verbal instruction, the child should be encouraged to role-play likely scenarios and/or rehearse possible responses. Older children may be encouraged to read to further educate themselves or take a self-defense course to increase their sense of confidence.

Putting It All Together: TF-CBT Case Conceptualization and Treatment Plan Templates

Theory-Specific Case Conceptualization: Trauma-Focused CBT

Trauma History

Type of trauma:

- Presenting trauma
  - Single incident, chronic, multiple
- Other traumas, which may include
  - Childhood abuse and neglect
  - Bullying, harassment
  - Immigration-related trauma
  - Natural disasters, war, terrorism
  - Serious childhood illness, or caretaker or sibling with serious/life-threatening illness
  - Major losses or deaths
  - Other
- Cultural/diversity issues related to abuse
  - Cultural interpretation/beliefs related to abuse
  - Cultural resources/limitations related to abuse

Trauma Symptoms

- *Cognitive functioning:* Dysfunctional thought patterns, learning problems, or concentration difficulties.
- *Relational functioning:* Increased conflicts with friends or family, avoiding friends or family, or impaired trust in interpersonal relationships.
- *Affective functioning:* Difficulty expressing emotions and/or managing feelings of anxiety, depression, or anger.
- *Family/Caretaker problems:* Parenting difficulties, parent-child conflict, difficulties with extended families, foster home placements, etc.
- *Traumatic behavior:* Avoidance symptoms, sexual acting out, aggression, and/or noncompliance.
- *Somatic symptoms:* Sleep problems, hyperarousal, headaches, stomachaches, or other physical reactions to traumatic memories or triggers.
- *Other psychiatric diagnoses:* Depression, anxiety, substance abuse, etc.

Functioning Prior to Trauma

- Temperament
- Coping skills
- Preexisting psychological issues
- Strengths and interests

To what degree are these still present in child's life?

Baseline Narrative

- Summary of positive event
  - Describe child's ability to identify feelings and thoughts: good, fair, poor
- Summary of trauma narrative
  - Describe affect, ability to discuss and describe events

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Parental Functioning

- Parental history of trauma from childhood to present
  - Have past traumas been clinically addressed?
  - Is parent currently experiencing trauma symptoms?
  - Does parent have sufficient support to work through own trauma?
- Parental response to child's trauma
- Parental coping: Good, fair, poor
  - Coping mechanism? Does parent's coping style affect child?
  - Is parent currently able to provide child needed support?
- Parent–child relationship/attachment prior to trauma
  - Parenting style and effectiveness
  - Cultural issues

Treatment Plan Template: Trauma-Focused CBT

This template can be used with children experiencing childhood trauma.

Treatment Plan

Initial Phase of Treatment

Initial Phase Therapeutic Tasks

1. *Develop working counseling relationship. Diversity consideration:* Consider client and family norms for physical and psychological safety based on ethnicity, gender, age, and so on.
   Relationship building interventions:
   a. Develop a **safe, supportive, and nurturing** relationship with client.
   b. Engage **parents/caretakers** in process, allowing them to feel **safe and valued** in treatment process.
   c. Provide **psychoeducation** about trauma and TF-CBT to engage child and family.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity considerations:* [Describe how you will consider cultural, gender, socioeconomic, sexual orientation norms when assessing client system as well as history of marginalization.]
   Assessment Strategies:
   a. Assess presenting **trauma** as well as **parental and other past traumas**.
   b. Asses **prior functioning** and obtain **baseline narrative**.

Initial Phase Client Goals

1. Increase **child's relaxation skills** to reduce anxiety and sense of feeling overwhelmed.
   Interventions:
   a. **Focused breathing** and **progressive relaxation**.
2. Increase **parent's supportive parenting skills** to reduce problem behaviors and increase sense of connection with child.
   a. Discuss ways to increase child's **sense of safety**.
   b. Instruct parents in how to use **praise** to encourage desired behavior and **selective attention, time-outs, and contingency management** to manage problem behaviors.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* [Describe how you will ensure that client and family needs for safety and direct discussion of trauma narrative are appropriate for age, gender, cultural background, etc.]

(*continued*)

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Assessment Intervention:

a. Emphasize **emotional safety** rather than techniques with child; **family sessions with psychoeducation** when preparing for work with trauma narrative.

Working Phase Client Goals

1. Increase client's ability to **express and modulate emotions** to reduce depressive and anxiety symptoms.
   Interventions:
   a. **Feeling identification** to increase ability to identify and communicate about full range of emotions.
   b. **Positive self-talk and thought stopping** to interrupt negative self-talk and intrusive thoughts.
   c. **Problem solving and social skills training** to address behavioral and/or anxiety issues.
2. *Increase* ability to use **cognitive coping strategies** to counter unhelpful thoughts to reduce depression and anxiety.
   Interventions:
   a. Use **cognitive triangle** to teach client how to identify unhelpful thoughts related to difficult emotions and problem behaviors.
   b. Use **cognitive triangle** to identify more helpful thoughts that lead to positive emotions and better behavioral choices.
3. Increase **integration and resolution of trauma memories** into cohesive narrative to reduce intrusive and avoidance trauma symptoms.
   Interventions:
   a. Prepare child and parents with **psychoeducation about trauma narrative intervention**.
   b. Facilitate verbal sharing of **trauma narrative** along with written narrative; reviewing and rereading until a complete narrative is constructed.
   c. Once child has completed narrative, use **cognitive challenging** to identify unhelpful beliefs and replace them more with more realistic and helpful beliefs.

Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity considerations:* Include individual, family, and community resources as supports, such as religious and ethnic community groups that may support family in healing.
   Intervention:
   a. **Psychoeducation** to develop plans, strategies, and skills to **enhance future safety**.

Closing Phase Client Goals

1. *Increase* **normal activities** to reduce avoidance symptoms and anxiety.
   Interventions:
   a. Use **in vivo mastery** to address any remaining fears or avoidance behaviors.
2. *Increase* strength of **parent-child emotional bonds** to reduce isolation and behavioral problems.
   Interventions:
   a. **Conjoint sessions** to review **trauma narrative** and increase open communication and sense of safety.
   b. **Conjoint sessions** to discuss strategies for **enhancing future safety**.

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Research and the Evidence Base

Both DBT and TF-CBT are listed on the SAMSHA's National Registry of Evidence-based Programs and Practices. DBT has been found to be effective with several difficult-to-treat populations. One recent study examined the long-term effectiveness of DBT by conducting a meta-analysis of 16 separate studies; results indicated a moderate effect for suicidal and self-harming behavior (Kliem, Kröger & Kosfelder, 2010). Similarly, a recent meta-analysis of five DBT clinical trials indicated that DBT was more effective than treatment-as-usual for addressing suicide and parasuicide; but no differences were found in reducing client drop-out or depression symptoms (Panos, Jackson, Hasan & Panos, 2014). One study examined the effectiveness of DBT in an intensive outpatient treatment center serving primarily clients with depression, anxiety, and/or substance abuse; results in this study found a significant decrease in depression and anxiety during an average of six weeks of treatment (Ritschel, Cheavens, & Nelson, 2012). In addition, a meta-analysis of nine different studies on using DBT with eating disorders indicated that the treatment may be efficacious for reducing eating disorder symptoms and comorbid depression symptoms (Lenz, Taylor, Fleming, & Serman, 2014).

TF-CBT was developed from clinical trials studying the most effective treatment for treating childhood trauma (Cohen et al., 2012). There have been over 22 scientific investigations, including 12 randomized clinical trials, making it one of the most researched evidence-based treatments for treating childhood trauma (Cohen et al., 2012). This evidence base, combined with its feasibility in routine practice, has made it one of the most widely used evidence-based treatments. The results of these studies indicate that the approach can be effective for children who have been sexually abused, exposed to interpersonal violence, terrorist acts, traumatic grief, and natural disasters (Cohen et al., 2012). For example, in a study comparing TF-CBT to child-centered therapy, the children receiving TF-CBT had significantly reduced PTSD, depression, anxiety, and shame, and the parents reported significantly less abuse-related distress and depression themselves, as well as improved parenting (Cohen, Deblinger, Mannarino, & Steer, 2004). Similar results have been found in international contexts (Jensen et al., 2014; Murray & Skavenski, 2012; Murray et al., 2013). Additionally, in trials with young children aged 4 to 11, both the 8- and 16-session formats were found to be efficacious, indicating treatment can be delivered very efficiently (Cohen et al., 2012).

Tapestry Weaving: Working with Diverse Clients

Cultural Diversity

DBT has been described as easily adaptable to culturally diverse groups because of the inherent flexibility of the model and its use of client-centered values (Neacsiu, Ward-Ciesielski, & Linehan, 2012). In one study that investigated the effectiveness of DBT with diverse clients, none of several diverse factors, including ethnicity, education, or age, were predictive of change, drop-out, self-injury, or suicide attempts, indicating that diverse clients may equally benefit from DBT. In Sweden, a pilot study was conducted to examine the feasibility and effectiveness of DBT in a non-U.S. setting; and DBT was found to be well received by adolescent and adult clients diagnosed with borderline personality disorder in Sweden (Hjalmarsson, Kåver, Perseius, Cederberg, & Ghaderi, 2008). Similarly, DBT has been adapted for use in Thailand with adolescents (Snitbhan, 2014).

TF-CBT has been used internationally and thoughtfully adapted/enhanced for specific ethnic groups in the United States. Internationally, TF-CBT has been used in Western Europe, Africa, Southeast Asia, and East Asia (Murray & Skavenski, 2012). In Western European settings, including Germany, Italy, Netherlands, Norway, and Sweden, researchers found that few modifications besides language were necessary; the primary modification made was to "tone down" the praising element of the parenting

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skills training in order to fit better with cultural parenting norms. In low-resources settings, such as Cambodia, the Republic of the Congo, Tanzania, and Zambia, more adaptations were necessary. In contexts where families were less familiar with Western counseling and psychotherapy models, more psychoeducation about TF-CBT and trauma was necessary to successfully engage the child and family. When teaching parenting skills, more time was spent first assessing the parents' current practices and beliefs, which may include shouting and spanking. The trauma narrative often involved timelines in countries such as Zambia or Cambodia, where children and families may have been exposed to multiple traumas due to war and sex trafficking. Culturally relevant metaphors were used to explain how gradual exposure, by retelling the narrative several times, could help the child heal from the trauma.

TF-CBT and Latino Children and Families

TF-CBT has been adapted for use with Latino families by de Arellano, Danielson, and Felton (2012). Latino youth experience more trauma than other ethnic groups, with Latinas having the highest rate of childhood sexual abuse of any ethnic group. Additionally, many Latinos have experienced trauma prior to immigration to the United States or as part of their immigration experience. De Arellano and colleagues provide several specific suggestions for making TF-CBT culturally relevant to Latino families. Some of these adaptations include:

- *Familisimo:* Most Latino families value close ties with the family, *familisimo*, often having very close ties with extended family members. Children often have aunts, uncles, and grandparents who are intimately involved with their daily care and involved with their upbringing. When initially assessing Latino families, counselors should try to collect information from all of the caretakers in the child's life, and, with the child and family, determine who might be important or useful to include in the treatment process.
- *Somatic Complaints:* Physical symptoms, such as stomach- or headaches, are common manifestations of emotional distress in Latino cultures; such symptoms should be monitored as part of the treatment of trauma.
- *Language and Trauma Encoding:* Language is a particularly important issue when treating trauma. Some research suggests that trauma treatment may be most effective when conducted in the language in which the trauma was encoded. Thus, if the child was primarily a Spanish speaker at the time of the trauma, or if the abuse perpetrator spoke in Spanish during abuse, then treatment may be most effective when done in Spanish.
- *Forms of Trauma:* When working with Latino clients, counselor should assess for traumas related to immigration, such as witnessing physical or sexual violence, human trafficking, or drug-related violence. Additionally, immigrants frequently experience trauma related to discrimination, racism, and separation from family.
- *Relating with Personalismo and Respecto:* A warm, friendly demeanor, *personalismo* is highly valued in Latino culture, and with professionals it may take the form of invitations to important family evens such as a baptism or wedding. Personalismo is balanced with *respecto*, a recognition of social roles, hierarchies, and boundaries.
- *Spiritualismo and Fatalismo:* Many Latinos have a deep sense of *spiritualismo*, or spirituality. This sense of spirituality may include *fatalismo*, the belief that "God will provide." Fatalismo sometimes leads families to believe that God will provide the healing the child needs. De Arellano et al. (2012) suggest reframing this view to suggest that the therapy is part of this divine plan for healing.
- *Bien Educado:* Latino families raise their children to be *bien educado*, which literally translated means "well educated." Not a referral to academic education, this expression refers instead to being respectful of adults, humble, and affectionate with the family. When teaching parenting skills, counselors should learn about the parent's approach to raising children and be aware that many may strongly value children who are respectful and dutiful.

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- *Machismo:* Boys and fathers who adhere to traditional gender roles may believe that expressing vulnerable emotions or vulnerability is not considered manly. To overcome this, the counselor can discuss how difficult it is to discuss painful emotions and that the ability to do so is a sign of strength, and, as such, can be considered a form of *machismo*.
- *Marianismo and Virginity:* When a Latina child has been sexually abused or raped, she and her family may be particularly concerned about the loss of her virginity, which is highly valued by many religious Latinos. In such cases, the counselor can provide an alternative definition of virginity as something that can only be given, not taken away. Because the child did not give away her virginity willingly, she is still a virgin in the religious sense. In some cases, working with a priest to share this message with the family can be particularly effective in addressing parents' concerns.

TF-CBT and American/Alaskan Indian Children and Families

TF-CBT has been enhanced to be more culturally relevant to American Indian and Alaskan Indian children and their families by BigFoot and Schmidt (2012). American and Alaskan Indian children are exposed to high rates of child abuse, domestic violence, substance-abuse-related loss, and other forms of violence. In addition, many also inherit a legacy of intergenerational violence, oppression, and relocation that has resulted in high rates of poverty, unemployment, family disorganization, and isolation. Childhood trauma is estimated at 22% and depression at 10–30% (BigFoot & Schmidt, 2012).

TF-CBT was selected as the foundation for the Honoring Children, Mending the Circle project, which was specifically designed to treat American/Alaskan Indian children who have experienced trauma. The model enhances TF-CBT by using Native American teachings and concepts and is built around a version of a traditional medicine wheel, with spirituality at the center. Each of the cardinal directions represents an aspect of wellness:

- North: Relational Well-being
- East: Mental Well-being
- South: Emotional Well-being
- West: Physical Well-being

The medicine wheel is a healing tool and symbol that is found in Native American cultures. BigFoot and Schmidt (2012) use the medicine wheel to teach the various components of TF-CBT (see Figure 10.4). Spirituality is placed at the center of the wheel, as native culture conceptualizes Spirit at the center of a healthy, well-balanced life. Personal imbalance manifests as disharmony in one or more areas of the wheel. Healing involves restoring balance and harmony to each of the five areas of the medicine wheel.

When working with clients to establish goals, TF-CBT counselors and their clients can use the wheel to identify specific a) goals and b) activities for each area. The wheel is particularly useful for clients who have high affiliation with their native culture and/or hold its healing traditions in high regard. It can also be particularly useful for engaging parents and caretakers in the TF-CBT process. When addressing emotional well-being with the affective modulation component of the approach, counselors should explore the child's role models for, and the family's beliefs regarding, emotional expression. Healthy expression of emotion in culturally relevant ways may be promoted through activities such as the creating of masks, shields, totems, beading, and paintings.

Of particular significance is the enhancement of the trauma narrative intervention using native traditions. American and Alaskan Indians have a strong and notable storytelling tradition. However, some Native Americans may believe that to retell a trauma narrative invites it to reoccur. Similarly, in the case of traumatic grief, some native teachings discourage discussing a deceased love one because it hinders the spirit's transition to the next world. In such cases, working with a recognized tribal leader or spiritual healer may help the family become more comfortable with the trauma narrative process. Once the child and family are comfortable with initiating the trauma narrative, culturally relevant options for documenting the narrative should be considered, such as a journey

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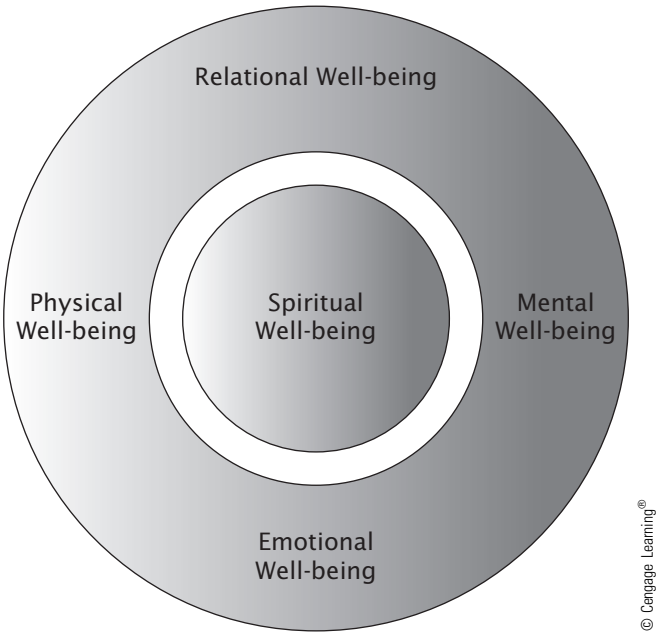

FIGURE **10.4.** TF-CBT Medicine Wheel

stick, totem, mask, pottery, song, or dance. In addition, the counselor should discuss with the child and family the option of involving spiritual helpers or healers in the process. Upon completion of the narrative, a healing ceremony with significant parties is often a welcome and meaningful tradition to incorporate. Furthermore, at the end of treatment, families with intergenerational trauma may wish to also honor the trauma of past generations through a similar healing ritual.

Sexual Identity Diversity

Little has been written specifically on using DBT with lesbian, gay, bisexual, or transgendered (LGBT) clients. Downs (2005) suggests using DBT strategies to help men successfully come out. He presents a three-stage model based on the gay men in his practice.

1. *Overwhelmed by Shame:* This stage describes when a man is "in the closet" and fears his own sexuality.
2. *Compensating for Shame:* The gay man tries to compensate for his sense of shame by becoming highly successful, masculine, outrageous, and so on. During this stage, a man may take many sexual partners to prove his worthiness and attractiveness.
3. *Discovering Authenticity:* The final stage involves becoming authentic by pursuing one's true talents and passions; during this stage, DBT strategies are encouraged to help develop skills for coping with the shame and pain of social marginalization.

DBT Case Study

April is a 29-year-old Caucasian female of Scandinavian descent who is seeking therapy due to her poor employment history and a recurring pattern of abusive relationships with partners. April is an aspiring actress who is also a server at a local restaurant. She states that there are a lot of "stupid people" in the restaurant business and that she's not afraid to "tell someone off." In her last job, April was fired by her manager for getting into a verbal argument with a customer. And in the job before, April stopped attending work because her scheduling supervisor wasn't accommodating her acting auditions. April also has a lot of emotional instability in her romantic relationships.

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She states that she enters into a relationship and that it is "wonderful for the first couple weeks," but it then quickly becomes verbally abusive. April will use cutting as a way to deal with her unstable relationships. She finds that she is often attracted to the "bad boys." April comes from an alcoholic family in which her father was emotionally and physically abusive. She has also been to two therapists before, but stopped attending sessions regularly because the therapists "didn't know what they were doing."

Case Conceptualization: DBT

Suicidal and Self-Harming Behavior

April's self-harming behaviors serve as a way for her to cope with her overwhelming feelings of anxiety and anger. Her self-harming behavior includes cutting and often occurs after an argument with a partner or when the client feels overwhelmed emotionally with family members. April does not have a history of past suicide attempts, but does have suicidal ideation on a regular basis, which will need to be monitored throughout her therapy.

Therapy-Interfering Behaviors

April has a history of arriving late to therapy sessions, missing appointments, and abruptly ending therapy, all of which interfere with her ability to build a therapeutic relationship with her therapist and gain the necessary support for her treatment. With her last two therapists, April stopped attending sessions because her therapists didn't respond quickly enough to her phone messages when she was having a crisis.

Quality-of-Life-Interfering Behaviors

- **Risky sexual behavior**
  April doesn't practice safe sex regularly with her sexual partners. She reports that she gets caught up in the moment and that she doesn't think about using condoms. She isn't currently practicing birth control.
- **Extreme financial difficulties**
  Due to April's difficulty in keeping employment, she is unable to pay for her expenses on a regular basis. The lack of a stable income leads to late payments on her utility bills and monthly rent, which increases her level of anxiety and emotional instability.
- **Severely problematic and/or abusive interpersonal relationships**
  April has been unable to maintain a stable relationship and finds herself attracted to men who end up being verbally abusive. She frequently leaves relationships after a few weeks when her partner will do something wrong or make her angry.
- **Occupational or school-related problematic behavior**
  April has been unable to keep steady employment due to her interpersonal problems and inconsistent performance at work. She has not kept a job longer than six months and has either quit or been let go due to verbal arguments with customers and supervisors. Difficulties with emotional regulation during stressful situations are contributing to April's problems in keeping employment.

Invalidating Environments

April has a history of invalidating environments in her family of origin and in her adult intimate relationships. She grew up in an alcoholic family where her needs and emotions were not validated but rather were criticized by her father. Her family accommodated her father's alcoholic behavior by trying not to provoke him. In addition, April has also experienced the same type of invalidation by her romantic relationships in which her past partners have been verbally abusive and unable to validate her feelings.

Trauma History and Marginalization

April has had a history of physical and emotional abuse in her childhood by her parents. She grew up in a family with an alcoholic father who was physically and emotionally abusive to her and her mother. She reports often feeling abandoned by her mother, who

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would often disappear for days in her room after an incident. Furthermore, rather than soothe her, April's mother would tell her she needs to behave better to avoid upsetting her father. April reports that she also experienced verbal abuse from her past partners.

Behavior Chain Analysis

Problem behavior: Arguing with work supervisor when feeling micromanaged.

Step-by-step description of chain of events related to problem:

- *Physical or other vulnerabilities prior to episode:* Client did not get enough sleep night before; did not eat healthy.
- *Events leading up to episode:* Client felt controlled and uncomfortable in sexual relationship with partner the previous night.
- *Step-by-step description of the problem behavior:* Client was asked by her supervisor to clean the silverware and put out the napkins; client responds with a sarcastic comment; supervisor pulls the client aside and tells the client to not respond sarcastically again; client angrily responds by stating she knows her job responsibilities; client is written up by supervisor for disrespectful attitude.
- *Consequences of the problem behavior:* Client is emotionally angry and has further strained relationship with supervisor.

Treatment Plan: DBT

Initial Phase of Treatment

Initial Phase Therapeutic Tasks

1. *Develop working counseling relationship. Diversity consideration:* When setting limits and boundaries, consider client history of abuse and neglect as well as family's Scandinavian background and possible need for more space and privacy.
   Relationship building interventions:
   a. Balance **nurturing** and **acceptance** of the client with **benevolent demands** for **change**.
   b. Use **validation** to increase client comfort with **commitment to** treatment.
   c. Develop a clear **client agreement** that outlines the length of treatment, terms of treatment, and handling of crisis situations; also include a **practitioner agreement** that describes what the counselor agrees to do.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity considerations:* Assess family and broader support system in childhood; consider impact of father's alcoholism and domestic violence in family system.
   Assessment Strategies:
   a. Assess for history of **trauma** and **invalidating environments** as well as current **suicidal, therapy-interfering, and quality-of-life-interfering behaviors**.
   b. **Behavioral analysis** to identify how specific problem behaviors are reinforced.

Initial Phase Client Goals

1. *Decrease* and ultimately stop **self-harming behaviors** to reduce sense of hopelessness and feeling overwhelmed.
   Interventions:
   a. **Commitment strategies** to motivate client to stop/reduce self-harm behaviors.
   b. **Behavioral chain analysis** to identify behavioral reinforcers.
   c. **Solution analysis** to identify alternative adaptive behaviors to manage feeling overwhelmed and/or hopeless.

(*continued*)

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2. *Decrease* risky sexual behavior, extreme financial difficulties, and arriving late/missing therapy appointments to reduce emotional lability.
   a. **Behavioral analysis** and **insight analysis** to identify behavioral reinforcers of risky sexual behavior and poor decisions that lead to financial difficulties.
   b. **Commitment strategies** to motivate client to improve attendance in counseling and group session.
   c. **Solution analysis** to identify alternative behaviors for risky sexual behavior, running late to appointments, and poor financial decisions.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* Ensure that limits are working for client, given trauma history and Scandinavian background.
   Assessment Intervention:
   a. Use **validation** to acknowledge difficulties that client might be having with client–counselor relationship.

Working Phase Client Goals

1. Increase client's ability to **regulate emotions** to reduce labile affect and impulsive behavior in the client's relationships.
   a. Use **emotional validation** to help client recognize and expression emotions; assess family and Scandinavian norms.
   b. Support client in practicing **emotional regulation skills**, such as labeling emotions, challenging myths, reducing negative emotions, and increasing positive emotions, whether related to relationships or work.
   c. Combine **behavioral analysis**, **insight strategies**, **and solution analysis** to identify more adaptive responses to stress, especially at work.
   d. Encourage use of **wise mind** to help client balance emotions and intellect.

2. *Increase* **interpersonal effectiveness** in personal and work relationships to reduce interpersonal conflict.
   a. Use **emotional**, **cognitive**, **and behavioral validation** to help client understand how she experiences and behaves in relationships, and to feel that these are understandable to another.
   b. Support client in using **interpersonal effectiveness skills**, such as challenging myths, using low-intensity requests, and practicing skills in community.
   c. Combine **behavioral analysis**, **insight strategies**, **and solution analysis** to help client identify more adapt strategies for relating to others.
   d. Use **contingency management** and **limit setting** within the counseling relationship to practice interpersonal skills.

3. Increase **distress tolerance** and ability to accept "what is" in current relationships to reduce crisis behaviors and emotional lability.
   Interventions:
   a. Use **emotional**, **cognitive**, **and behavioral validation** to help client feel that thoughts, feelings, and behaviors related to distressing situations are understandable.
   b. Encourage client to use **distress tolerance skills**, such as self-soothing, distraction, and mindful breathing.
   c. Use **solution analysis** and **wise mind** to help client find appropriate responses in distressing situations.

(*continued*)

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Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity considerations:* Explore possibilities for family support and/or support within local community.
   a. Identify specific **relationships, support groups, and favorite skill exercises** that client can use post-termination to maintain gains.

Closing Phase Client Goals

1. *Increase* sense of resolution regarding past physical and emotional **trauma** from childhood to reduce anger and withdrawing behaviors in relationships.
   a. Use **emotional, behavioral, and cognitive validation** to help client feel validated regarding experience(s) of past trauma.
   b. Use **insight strategies** to help client make sense of trauma memories and narrative.
   c. **Solution analysis** to identify alternatives to specific trauma symptoms.
   d. Encourage use of **wise mind** to help client make sense of past traumas.
2. *Increase* **self-respect** and ability to pursue relational and career **goals** to reduce sense of worthlessness and hopelessness.
   a. **Validate** client career goals and aspirations while simultaneously helping client learn to **self-validate** when appropriate.
   b. **Solution analysis** to help client identify adaptive strategies to achieve acting career and relationship goals.
   c. **Insight strategies** to help client develop self-respect and self-compassion.

Questions for Personal Reflection and Class Discussion

1. After reading about two evidence-based treatments for specific populations, what are your thoughts?
   - What did you like about having a specific approach?
   - What limitations did you see?
   - Did it seem more structured, less structured, or about the same, when compared to other approaches?
2. Describe how you have experienced the dialectic tension between change and acceptance in your life.
3. Describe a relationship in which you or the other party was both a) nurturing and b) benevolently demanding.
   - How were these two opposites expressed and experienced within the relationship?
   - How were challenges overcome?
4. Describe a time when you used wise mind to make a difficult decision.
5. How might you create a safe relationship with a child who has been traumatized?
   - How might you create a safe relationship with the child's parent if the parent had also been traumatized (e.g., domestic violence or natural disaster)?
   - How might connecting with a parent be different if the parent were not recently traumatized?
6. Does the idea of creating a trauma narrative make intuitive or logical sense to you? Why or why not?
7. Use the cognitive triangle with a current problem situation you are having. Does it help you to see the situation differently?
8. What strengths do these approaches have for working with diverse clients? What limitations?

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9. What connections do you see between DBT and TF-CBT? (hint: trauma)
10. Both approaches involve extensive psychoeducation and homework. How would you try to motivate a busy individual or family to use the information and do the homework?

Online Resources

Behavioral Tech: DBT Training Institute
http://behavioraltech.org/index.cfm

Client-Maintained Site for DBT
http://www.dbtselfhelp.com

Linehan Institute
http://www.linehaninstitute.org

Trauma Focused CBT Free Web-Based Training Website
http://tfcbt.musc.edu

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CHAPTER

11

Systemic Family Counseling and Therapy

The family is not a static entity. It is in the process of continuous change, as are its social contexts. To look at human beings apart from change and time is solely a construct of language. Therapists, in effect, stop time when they look at families, like stopping a motion picture to focus on one frame.

—Minuchin and Fishman (1981, p. 20)

Lay of the Land

Got to love 'em even though they drive us batty: our parents, partners, children, in-laws, extended family—thank goodness we can add a dog, good book, headphones, and a few hundred miles of space into the mix to preserve our sanity. What is it about our families and partners that can push our buttons: that can make us act—dare I say—crazy? Hmmm. We might be on to something here.

The vast majority of clients present with some form of relational issue: I'm depressed because I broke up with my boyfriend, or my anxiety started in childhood when my mother would correct everything I said and did. For this reason, all counselors should consider the larger relational system and how it relates to the concerns that clients bring. Systemic counselors make this their primary means of understanding and intervening.

Systemic approaches were originally developed for work with couples and families. They represent a unique set of theories that conceptualize an individual's symptoms as arising within family and relational dynamics and serving to balance the family dynamics in some way. Developed in the 1960s, systemic approaches represented such a radically new way of working that they inspired a separate discipline and license to support this distinctive approach. In fact, the field of family therapy, which is the focus of those who study to become marriage and family therapists, has enough theories to fill its own textbook, and many textbooks have been written on this topic, including one by myself (Gehart, 2010).

Thus, I will not endeavor in this text to scantily cover the same material that fills another book—that would guarantee my failure *and* a funky treatment plan and would most likely leave even the brightest readers more confused than when they began. Furthermore, I have had several students report hurling confusing texts across the room, so my most modest goal here is to not go splat! Instead, this chapter will present a *general,*

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integrated systemic counseling approach that counselors, psychologists, social workers, and family counselors can use as their primary theoretical approach for working with individuals, couples, and families. At the very least, systemic ideas are useful to counselors of any theoretical stripe during the initial case conceptualization process in identifying systemic dynamics that may be affecting an individual (see Chapter 16) or when working with couples or families. In short, I hope to provide a meaningful, coherent, integrated systemic counseling approach rather than briefly review each of the 15-plus family therapy approaches that rightly deserve their own book.

In this chapter, I distinguish *systemic family counseling* from generic *family counseling*, which can refer to a wide range of counseling models, including Adlerian, solution-focused, or psychodynamic family counseling. I use the term "systemic" as it is generally used in counseling, psychology, and social work, which is quite different from the use of the term "systemic" within the field of family therapy, where virtually all of the theories are systemic, and thus they must make far finer distinctions. Translated into the more delicately delineated language in the field of family therapy, this chapter will specifically cover a primarily structural-strategic family therapy approach, which is the most commonly used, especially in newer evidence-based approaches. This systemic approach also covers many key principles that are shared with other major family therapy schools, such as Bowen's intergenerational and Satir's human growth models; however, to fully understand the unique methods of conceptualization and intervention in these theories, I encourage curious readers to read Gehart (2010) or a similar text for further details (note that single chapters on these theories can be purchased separately for a minimal fee).

The systemic counseling approach in this chapter is based on several of the seminal models of family counseling:

- *Mental Research Institute (MRI):* Located in Palo Alto, California, next to Stanford University, MRI was established after Gregory Bateson (see "Rumor Has It: People and Places") and his research team concluded their groundbreaking research on communication in families that have a member diagnosed with schizophrenia. Richard Fisch and Don Jackson worked together to found MRI, which has since served as the most influential training center in family therapy, inspiring Jay Haley's strategic therapy, the Milan team's systemic approach, Virginia Satir's human growth model (see Satir's Human Growth Model), and solution-focused brief therapy (see Chapter 12). A gifted clinician, Don Jackson developed many of the foundational theories of the field at MRI before his early passing. Later, using action-based interventions, Paul Watzlawick, John Weakland, and Richard Fisch began the ambitious Brief Therapy Project to find the quickest possible resolution to client complaints, developing the original brief therapy model (Watzlawick & Weakland, 1977; Watzlawick, Weakland, & Fisch, 1974; Weakland & Ray, 1995).
- *Milan systemic (long-term brief counseling):* Originally working with anorectic and schizophrenic children, Mara Selvini Palazzoli, Gianfranco Cecchin, Giuliana Prata, and Luigi Boscolo constituted the Milan team, who studied at MRI and returned to Italy with the goal of designing a counseling model that embodied a pure cybernetic (see the section "Systems 101: Philosophical Foundations") systems theory as articulated by Gregory Bateson (1972, 1979). Less action-oriented than their California peers, Milan counselors closely attend to how client language shapes the family dynamics and then use this language to alter family interaction patterns (Selvini Palazzoli, Cecchin, Prata, & Boscolo, 1978).
- *Strategic:* One of the original associates at MRI, Jay Haley developed his own form of systemic therapy with his wife at the time, Cloe Madanes. Their approach focuses on the use of power and, in their later work, love in family systems (Haley, 1976).
- *Structural:* The most down-to-earth and practical, the structural approach developed by Salvador Minuchin involves mapping family structure—boundaries, hierarchy, and subsystems—and then actively engaging the family to help them develop a relational structure that eliminates the needs for symptoms and enables all members to thrive.

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Systems 101: Philosophical Foundations

Before we get to what happens in the counseling room, we should first explore the philosophical foundations of the often counterintuitive practice of systemic counseling. These ideas, which are also presented in full detail in chapter 8 of *Mastering Competencies in Family Therapy* (Gehart, 2010), are known for making heads spin, ache, and fog over—or so my students report. So, read slowly and on a steady surface.

General Systems and Cybernetic Systems Theories

Systems theory has its origin in the cross-disciplinary study that began at the Macy Conferences, which were attended by rocket scientists building self-guided missiles, anthropologists studying intertribal interactions, and ecologists studying the interactions between species, among others. These researchers discovered that whether studying mechanical parts, social groups, or animals, they were noticing that systems operated using the same basic principles. From these conferences, von Bertalanffy (1968) developed *general systems theory*. Closely related but more focused on social systems was *cybernetic systems theory*, articulated by Gregory Bateson (1972), which has had the most influence on mental health counseling approaches.

Cybernetics, Homeostasis, and Self-Correction

The term "cybernetic" refers to "steersman" in Greek, which hints at the functional principles of cybernetic systems: they are *self-correcting* and therefore able to "steer" their own course, unlike a computer, for example, which needs an outside entity to steer it (Bateson, 1972). What does a cybernetic system steer toward? *Homeostasis*. Homeostasis, in the case of families, refers to the unique set of behavioral, emotional, and interactional norms that create stability for the family (or other social group). Despite what the name might imply, homeostasis is not static but *dynamic*. Much like a gymnast constantly moves to maintain her balance on a beam, systems must be constantly in flux in order to maintain a sense of stability. In all living systems, it takes work to maintain balance, whether it be in mood, habits, weight, or overall health. The key to maintaining stability is the ability to self-correct, which requires feedback.

Negative and Positive Feedback

You can pretty much guarantee that negative and positive feedback will be on any multiple-choice test about family counseling. Why? Because the disciplinary use of the terms are *opposite* of the colloquial use of the terms. So, remember, the negative and positive feedback questions are always *trick questions*—that is, if you haven't studied. Here's how to remember it:

> **Negative Feedback** = *No* new information to steersman = waters are the *same* = Homeostasis
>
> **Positive Feedback** = Yes, new information is coming in to the steersman = waters are choppy, moving faster, colder, etc. = Something is *changing*

Negative feedback is "more of the same" feedback, meaning there is no new news or change (Bateson, 1972; Watzlawick, Bavelas, & Jackson, 1967). Much like "positive test results" in medical parlance, positive feedback is news that things are not within expected parameters, which is or may be experienced as a problem or crisis, depending on the situation. The problem or change could be due to what is generally considered "bad news" (death of a loved one, a fight with a spouse, a problem at work, and so on) or "good news" (graduation from college and needing to find a job, getting married and starting a new household, moving to a new city for a job, and such). Both good and bad news can create positive feedback loops, which result in one of two options: (a) return to former homeostasis or (b) creating a new homeostasis.

In most cases, a system's response to positive feedback is to try to get back to its former homeostasis as quickly as possible. After a fight, most couples quickly want to

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make up and "get back to normal." After a death, most talk about how "getting back to normal" will take a while; depending on how significant that person was, this may or may not be possible, because sometimes it is not possible to get back to the "old normal," and a new normal needs to be created. The need for a new norm or homeostasis is also referred to as "second-order change."

First- and Second-Order Change

Second-order change refers to when a system restructures its homeostasis in response to positive feedback, and rules that govern the system shift fundamentally (Watzlawick et al., 1974). *First-order change*, of course, then refers to when the system returns to its previous homeostasis after positive feedback. In first-order change, the roles can reverse (e.g., a former distancer in a relationship could start pursuing—which seems like a radical change if you are in the relationship), but the underlying family structure and rules for relating stay essentially the same. This type of first-order shift is frequent in the early stages of counseling with couples when they shift roles being the pursuer and distancer. For example, if in the beginning the woman was asking for more closeness from her husband and he was asking for more space, as counseling progresses they may shift roles, and so the problem may appear solved on the surface. However, functionally there has been no shift in the rules that regulate intimacy in the relationship; they just have switched roles so that it looks and feels different.

A second-order shift with this couple would involve reducing the overall pursuer-distancer pattern and increasing each person's ability to tolerate more togetherness and more distance. It is also important to remember that second-order change is not always necessary in counseling, depending on the client's situation. In terms of how clients experience them, first-order solutions make logical sense; second-order solutions seem odd and illogical because they introduce new rules into the system.

"One Cannot Not Communicate"

The early work of the Bateson team resulted in Watzlawick et al.'s (1967) classic text, *Pragmatics of Human Communication*, in which they proposed the following axiom: "One cannot not communicate." In addition to blatantly ignoring high school English teachers' rules about double negatives, this axiom seems to contradict the most common presenting problem of couples and families: "We can't (or don't) communicate." So, where did this axiom come from? What the Bateson team learned from their research of families with members diagnosed with schizophrenia was that even schizophrenic attempts to not communicate (e.g., nonsense, immobile states, etc.) still sent a message, often communicating a desire to not communicate. Since all behavior is a form of communication and it is impossible to not be engaged in some form of behavior (at least while we are alive), it follows that we are always communicating. As we all know, silence speaks volumes, as does nonsense, withdrawal, or a frozen pose; thus, even the most creative attempts to not communicate inherently send a message. More commonly, the claim that "we just can't communicate" means that the interlocutors reject what the other has to say, at which point it is helpful to examine the anatomy of the communicated messages, namely, the report and command aspects of communication.

Double Binds

Double-bind theory goes back to the Bateson group's earliest research on families with a member diagnosed with schizophrenia (Bateson, 1972). Watzlawick et al. (1967) identify the ingredients of a double-bind communication:

1. Two people are in an *intense relationship* that has a high degree of survival value, such as familial relations, friendship, religious affiliation, doctor-patient, counselor-client, social norms, and so on.
2. Within this relationship, a message is given that is structured with (a) *primary injunction* (e.g., a request or order) and (b) a simultaneous *secondary injunction* that *contradicts* the first, usually at the metacommunication level.

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3. Finally, the receiver of the contradictory injunctions has the sense that he or she *cannot escape* or step outside the cognitive frame of the contradictions either by metacommunicating (e.g., commenting on the contradiction) or by withdrawing, without threatening the relationship. The receiver is made to feel "bad" or "mad" for even suggesting there is a discrepancy.

Common examples are the commands "love me" or "be genuine," in which one person orders another to have spontaneous and authentic feelings. In their research, the MRI team noticed that this type of communication characterized families who had a member diagnosed with schizophrenia. A common type of exchange they noticed in these families was a mother who gives her child a cold, distant hug (command aspect communicates distance) and then says, "Why are you never happy to see me?" (report aspect suggests closeness). No matter how the child responds, the mother can prove him or her wrong. Thus, the "logical" response is a *nonresponse* or *nonsense response*, which characterizes schizophrenic behavior, such as word salad (spoken words that have no real meaning), loose associations (tangentially relating words or topics), or catatonic behavior (rigid, repetitive behavior that has no interactive meaning). Although the double-bind theory does not account entirely for how schizophrenia develops or who develops it, it is often useful for clinicians working with families that get stuck—whether or not there is a member diagnosed with schizophrenia.

Family as a System

The defining feature of systemic approaches to family counseling is viewing the family as a system: an entity in itself, the whole greater than the sum of its parts (Watzlawick et al., 1967). What does this really mean? Systemic counselors view the interactional patterns of the family as a sort of "mind" or organism that is not controlled by any single member, nor can it be controlled by an outside entity, such as a counselor. This view results in several startling propositions:

- *No single person orchestrates the interactional patterns:* The rules that govern family interactions are not consciously constructed like the U.S. Constitution; instead, they emerge through an organic process of interaction–feedback (reaction)–correction until a norm or homeostasis is formed. In fact, many of the arguments early in a relationship serve as feedback to shape the emerging relationship's homeostatic norms. In most cases, this whole process occurs with minimal metacommunication about how the relational rules are being formed.
- *All behavior makes sense in context:* Read that again—and then sit and think about it. Because if you really believe this and lead your life accordingly, everything changes (generally for the better), especially if applied to every other person you meet or hear about. Because all behavior is a form of communication, each behavior makes sense in the context in which it is expressed, within the rules of that particular system. Thus, even the most outrageous, inappropriate, or unexpected communication of those you meet on the street, at work, or at home makes sense in the appropriate context.
- *No single person can be blamed for family distress:* Because no one consciously creates the rules, but instead the patterns emerge naturally through ongoing interactions, it follows that no single person can be fully to blame for family problems; this means not that individuals do not simultaneously have moral and ethical obligations in cases of abuse but rather that the interactions "made sense," or at least are made possible, by the dynamics of the system.
- *Personal characteristics are system-dependent:* Although a member may display certain characteristics or tendencies, these are not inherent personality characteristics that exist independent of the system but rather they emerge from the interactional patterns in the system. Thus, even when a family reports that "Suzie has always been like this" (e.g., angry, helpful, forgetful, etc.), the counselor takes this to be a statement more about the rules and likely rigidity of the system than an inherent truth about Suzie.

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In a Nutshell: The Least You Need to Know

Systemic counselors always view a person as inherently part of larger *relational systems*, which include the *family of origin* (mother, father, siblings, extended family), *family of procreation* (spouse, partner, children, stepchildren, etc.), social communities (e.g., church, neighborhoods, and even online communities), as well as broader societal groups (e.g., gay/lesbian communities, ethnic communities, state, nation, and so on). Systemic counselors radically propose that a person's problems or symptoms are inherently related to the dynamics of these systems; thus, an individual's depression (or fill in the blank with any other symptom) plays a role in maintaining a sense of "normalcy" in the system. At the same time, systemic counselors maintain a *nonpathologizing* position, not blaming persons within the system or the system itself for the symptoms. Instead, symptoms are viewed more *neutrally* and with curious enthusiasm—much like an anthropologist trying to understand a long-lost culture—as a set of behaviors, feelings, and beliefs that help the system maintain a sense of balance or *homeostasis*. In the tiniest of nutshells, systemic counselors see their jobs as helping individuals and families find new relational patterns that do not require the symptom for the system or its members to feel balanced and connected.

Systemic counselors are the martial artists and Zen masters of the counseling world in that their interventions are rarely logical on the surface and often involve unusual Zen-like koans that serve to get people thinking in new ways. Much like a martial artist, they work *with* the symptoms, taking their energy and redirecting it in more productive ways rather than trying to forcefully stop a problem behavior, thought, or feeling. Thus, they *do not* reeducate individuals and families on how to better relate as do Adlerians and cognitive counselors. Instead, they use a wide variety of techniques to interrupt and redirect problem behavior sequences, often allowing the family to develop its own new ways of responding. They conceptualize families using two basic paradigms: (a) family structure: boundaries, hierarchy, and subsystems, and (b) systemic interaction patterns: repetitive interaction cycles related to the problem. Systemic counselors are *strength-focused,* never seeing individuals or families as dysfunctional but rather seeing people who need assistance in expanding their repertoire of interaction patterns to adjust to the ever-changing developmental and contextual demands.

The Juice: Significant Contributions to the Field

If there is one thing you remember from this chapter, it should be …

Enactments

Perhaps the most practical and researched systemic intervention, counselors use *enactments* to redirect symptom-laden interactions to interaction patterns that are more effective and satisfying (Colapinto, 1991; Minuchin, 1974; Minuchin & Fishman, 1981). Regardless of whichever counseling model you prefer to use in the end, you will need to master enactments. Why? Because most couples and families are going to start arguing in your office whether you ask them to or not, and even individual clients may need to be coached in how to appropriately communicate, so you better be prepared. Enactments are one of the best ways to handle dicey, difficult moments in session (or even the waiting room).

Systemic counselors prefer enactments to talking about interactions because often people describe themselves as being one way but behave quite differently (clearly, this does not apply to you or me; we are speaking hypothetically, of course). This incongruity is not because people are malicious or hypocritical but because it often is difficult to clearly see how our behavior looks from the outside (Minuchin & Fishman, 1981). Enactments are used to both assess and alter the problematic interactional sequences, allowing the counselor to *map, track,* and *modify* the family structure or an individual's interaction patterns.

As a counselor becomes more experienced, it requires only a couple of minutes of listening to an individual recounting a problem situation or watching a family interact to quickly know where and how to *restructure* boundaries and other relational structures. Restructuring may take the form of creating a clearer boundary in enmeshed relationships (e.g., stopping people from interrupting and speaking for one another), increasing engagement by encouraging the expression of empathy or direct eye contact,

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or improving parental effectiveness by helping the parent successfully manage a child's in-session behavior.

An enactment occurs in three phases (Minuchin & Fishman, 1981):

Phase 1: Tracking and mapping: Observation of spontaneous interactions: When talking with an individual or family, the counselor closely follows both content and metacommunication, listening for the assumptions that coordinate the interactions, such as demands for intimacy, independence, or control, as well as strengths and abilities. When talking with clients, the counselor *tracks actual transactions* (what is done in session) more closely than verbal accounts (Colapinto, 1991). Gathering information from what is observed, the content of what is said, and the metacommunication, the counselor develops a working hypothesis that *maps* the family's boundaries and hierarchy (Minuchin & Fishman, 1981). Once counselors identify an area for change, they are ready to invite the individual or family into the active phase of enactment.

Phase 2: Eliciting interaction: The invitation: Counselors issue an "invitation" for an enactment in one of two ways: either by the counselor directly requesting the individual or family to enact a real-world interaction or by the clients spontaneously engaging in the problematic behavior, usually in the form of an argument or stone-cold silence (Colapinto, 1991). Obviously, the counselor does not need to do much when the client spontaneously begins; otherwise, the counselor must issue an explicit invitation for the client to "show" the problem:

- "Can you reenact what happened last night?" or
- "Please show me what happens at home when he is 'defiant'; can you act out an incident of defiance that happened last week so I have a good idea of what the problem really is?"

Enactments can also be used with individuals by having them enact their half of the encounter and summarizing—or even using a puppet to say—what the other person said. Using enactments is important when working with individuals because it is easy to collude with them in blaming others. Although it solves nothing and typically makes the situation far worse (see the discussion of triangulation below), blaming others without holding oneself responsible for one's half of the dynamic is a favorite recreational sport for many. Counselors can avoid this common helper's pitfall when working with individual clients by using enactments to keep both counselor and client focused on the only element in the system that they can affect: the client.

Phase 3: Redirecting alternative transactions: Up to this point, the enactment process has just been the more-of-the-same interaction pattern and does not count as an intervention (and actually isn't helpful) until counselors actually help clients *do something different.* Thus, in this phase, the counselor redirects interaction patterns to clarify boundaries, hierarchy, subsystems, and other structural issues. How exactly counselors redirect the interaction depends on the particular dynamics assessed in the first phase. Some of the more common ways that systemic counselors redirect interactions include the following:

- *Reduce enmeshment:* Allow each person to finish speaking and stop interruptions
- *Reduce disengagement:* Encourage couples to share thoughts and feelings on difficult topics
- *Reduce triangulation:* Ask two people to talk directly to each other while asking a third (typically intrusive person) to remain quiet
- *Clarify boundaries:* Rearrange chairs physically to increase or decrease emotional closeness
- *Alter pattern with individual:* Direct him or her to rephrase or "redeliver" a request or response as if the other person were present
- *Increase parental hierarchy:* Direct a parent to set limits for a child in session (rather than the counselor doing it)

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Minuchin and Fishman (1981) identify several benefits of enactments, including providing real-life practice in new behaviors, shattering the illusion that the problem belongs to "the other" person, and increasing a person's sense of competence and confidence in handling the problem situation better.

Rumor Has It: The People and Their Stories

Gregory Bateson

Participating in the Macy Conferences with his then wife Margaret Mead, Bateson was a British anthropologist who explored cybernetic theory studying intertribal interactions in New Guinea and Bali (Bateson, 1972, 1979; MRI, 2002). Bateson's elegant and thoughtful articulations of cybernetic theory influenced numerous disciplines, including communications, anthropology, and family therapy. As part of his research of human communications, he assembled what was later known as the Bateson group: Don Jackson, Jay Haley, William Fry, and John Weakland. For ten years, he worked with the team studying communication in families with members diagnosed with schizophrenia, providing consultation on cybernetic theory, and introducing them to the trance work of Milton Erickson. Together with the team, they developed the *double-bind theory of schizophrenia* (Bateson, 1972), in which they reconceptualized psychotic behavior as an attempt to meaningfully respond in a family system characterized by double-bind communications. Bateson's prior anthropological research provided the team with a theoretical framework through which to view problematic human behavior as a function of the larger social systems rather than as being purely intrapsychic.

Don Jackson

A student of the founder of interpersonal psychoanalysis, Harry Stack Sullivan (who, I am sure you remember from Chapter 3, was criticized for relying on observable data more than on interpretation of the unconscious), Don Jackson was a key figure in the development of systemic family theories, taking a leading role in the development of foundational concepts such as family homeostasis, family rules, relational quid pro quo, conjoint therapy, interactional theory, and, along with others at MRI, the double-bind theory (MRI, 2002; Watzlawick et al., 1967). Jackson also was one of the first psychiatrists to question the myth of normality (Jackson, 1967), which 50 years later has finally been adopted as part of the international *recovery movement*.

John Weakland

Originally trained as a chemical engineer, Weakland joined the Bateson group helping to articulate the application of communication theory, emphasizing the importance of developing theory based on concrete and observable behaviors rather than on inferences or constructs, which are not observable (MRI, 2002). Along with Haley, Weakland was key in integrating Milton Erickson's work (see Chapter 12) at MRI as part of the Brief Therapy Project.

Richard Fisch

After initially proposing the creation of MRI, Richard Fisch was appointed by Jackson to be the director of the new Brief Therapy Project at MRI, a project inspired by Erickson's brief hypnotic work; the goal was to develop a highly teachable form of brief psychotherapy (Watzlawick et al., 1974). In addition to spearheading the development of the therapy model for which MRI is most famous, Fisch's research and contributions centered on how to influence others with words and indirect influence (Fisch & Schlanger, 1999; Fisch, Weakland, & Segal, 1982; MRI, 2002).

Paul Watzlawick

Born in Austria, Paul Watzlawick (Vats-la-vik—rhymes with "not Slavic") was a communications theorist who cofounded the Brief Therapy Center at MRI with Weakland and Fisch, the center's goal being to develop an ultrabrief approach to therapy (Watzlawick, 1977, 1984, 1990, 1993a). In his later writings, Watzlawick explored the

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implications of radical constructivism for therapy and human communication in cleverly titled books such as *How Real Is Real?* (1977), *The Invented Reality* (1984), *Ultra Solutions: How to Fail Most Successfully* (1988), and *The Situation Is Hopeless but Not Serious: The Pursuit of Unhappiness* (1993b).

Salvador Minuchin

Trained as a pediatrician and child psychiatrist, Salvador Minuchin developed the structural family counseling approach (Colapinto, 1991; Minuchin, 1974). Leading a life that taught him about diversity on numerous fronts, Minuchin was born and raised in Argentina, lived in Israel during two periods of his life, and settled in the United States, where he spent most of his professional life. Like Don Jackson, Minuchin studied with Harry Stack Sullivan (see Chapter 3), whose psychoanalytic work emphasized interpersonal relationships rather than unconscious processes. After his psychoanalytic training, Minuchin accepted a position at the Wiltwyck School for delinquent boys and suggested to his colleagues—Dick Auerswald, Charlie King, Braulio Montalvo, and Clara Rabinowitz—that they see the entire family of these problem children. With no formal models to follow, they used a one-way mirror to observe each other and developed a working model as they went along. In 1962, Minuchin visited MRI, where Haley, Watzlawick, Fisch, and others were at the forefront of developing family approaches. There he befriended Jay Haley, and the two formed an influential relationship in developing both structural and systemic forms of counseling; in fact, this cross-fertilizing friendship is the foundation for the integrated systemic approach presented in this chapter.

From 1965 to 1976, Minuchin severed as the director of the Philadelphia Child Guidance Clinic, and in 1975 he founded the Family Therapy Training Center (later renamed the Philadelphia Child and Family Therapy Training Center, which still operates today). In 1967, Minuchin, Montalvo, Guerney, Rosman, and Schumer published *Families of the Slums*, considered the first book to describe structural therapy, a book that also reveals an inherent sensitivity to viewing families with attention to poverty and diversity issues at a time when the term "multiculturalism" was not yet coined. This book is still a seminal piece for mental health providers working with poor families. Minuchin is still an active leader in the field, continuing to teach new generations of family practitioners (Minuchin, Nichols, & Lee, 2007). His influential students and colleagues include Harry Aponte, Jorge Colapinto, Charles Fishman, Jay Lappin, and Michael Nichols.

Jay Haley and Cloe Madanes

Jay Haley, one of the original members of the Bateson team, student of Milton Erickson, and cofounder of the Brief Therapy Project at MRI, developed his own systemic approach: strategic therapy (Haley, 1963, 1973, 1976, 1980, 1981, 1984, 1987, 1996; Haley & Richeport-Haley, 2007; MRI, 2002). He and his then wife Cloe Madanes (1981, 1990, 1991, 1993), founded the *Family Therapy Institute* in Washington, D.C. Their approach distinguishes itself by conceptualizing families using hierarchy, power, and love and their use of *directives* for interventions. As he and Minuchin carpooled for many years while developing their ideas, each man's work influenced the other's.

The Milan Team

Founded in 1967 to study families with children diagnosed with anorexia in Italy, the *Milan team* included Mara Selvini Palazzoli, Gianfranco Cecchin, Luigi Boscolo, and Guiliana Prata (Campbell, Draper, & Crutchley, 1991). They traveled to MRI in California to study the work of Bateson and continued an ongoing relationship with Watzlawick as they developed their unique theory that focused more on language than MRI's brief approach or Haley's strategic approach. In 1979, the team separated along interest and gender lines: Selvini and Prata, primarily researchers, wanted to continue their investigation treating families diagnosed with psychosis or anorexia, while Cecchin and Boscolo worked together, their attention focused on clinical and training applications. The later work of Selvini and Prata centered on the *invariant prescription* (see "Invariant Prescription to Sever Coalitions"), while Cecchin and Boscolo explored

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second-order cybernetics (see "First- and Second-Order Change"), attending to language and the construction of meaning through multiple descriptors, eventually moving toward a more postmodern, social constructionist stance (see Chapter 13).

Big Picture: Overview of Treatment

Systemic counseling focuses on resolving the presenting problem, with the counselor imposing no other goals or agendas based on theories of normalcy. Systemic counselors view the presenting problem not as an individual problem but as a relational one, specifically an *interactional* one, even if the counselor is working with an individual (Cecchin, 1987; Haley, 1987). Systemic counselors conceptualize interaction using two lenses: (a) identifying problematic interaction sequences and (b) mapping family structure, including boundaries, hierarchy, and coalitions. In this approach, neither an individual nor a relationship is considered "dysfunctional"; instead, the problem is viewed as part of the interactional sequence of behaviors that have emerged through repeated exchanges with no one person to blame (the sure sign that a counselor does not understand systems theory is when he or she uses the word "dysfunctional" or implies that if only person X changed, everyone else in the system would be fine).

In the early phase, the counselor observes and maps the problem behavior by obtaining a detailed description of the behavioral sequence surrounding the problem and by observing how clients interact. Often counselors achieve this by having them *enact* the problem situation (see "The Juice"). Once the counselor has identified the interactional behavioral patterns and meanings associated with the problem, the counselor uses one of many potential interventions to *interrupt* and *alter* this sequence—not necessarily correct it. By simply interrupting highly repetitive and rigid interaction patterns that constitute a problem (a problem wouldn't be a problem if it weren't highly repetitive and resistant to change), the system—which is inherently self-correcting and seeking balance—will effortlessly reconfigure itself around the new information that has been introduced. For example, if a man complains of frequent arguments with his partner, the counselor does not try to educate him in better communication skills. Instead, the counselor strives to simply *interrupt* the sequence by having him do *one thing different*, often a small, personally symbolic, easily achieved behavioral change, such as scheduling arguments at random times during the week or passing a symbolic object during the argument. Alternatively, the counselor may offer a reframe to give new meaning to the arguments that radically alters how they are viewed, such as a way to build connection and in some special way show love. Another option would be an enactment to help the client find new ways to interact more effectively. Any of these tactics of change will interrupt the problem sequence and allow for self-correction, resulting in new actions, thoughts, and behaviors.

Counselors frequently give clients some form of homework, sometimes a specific behavioral task or a cognitive reframing that highlights the systemic nature of the problem. Each week, the counselor follows up on the prior week's homework and then designs another task or reframe based on the client's response. This continues just as long as is necessary to resolve the presenting problem, and then counseling is terminated. To recap, the general flow of systemic or strategic therapies is as follows:

The Process of Systemic Counseling

Step 1: Assess the interactional sequence, family structure, and associated meanings: Identify interactional behavior sequences that constitute the problem, including the actions and reactions of everyone in the system and the associated meanings; assess boundaries, hierarchy, subsystems, and coalitions (see "The Viewing: Case Conceptualization and Assessment" section).

Step 2: Intervene by interrupting and redirecting the interactional sequence: Using a reframing technique or a task, the counselor interrupts the sequence, allowing the

(*continued*)

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family to reorganize itself in response to the intervention. *The differences between the specific schools of MRI, strategic, Milan, and structural are seen primarily in the preferred method of interrupting the interactional sequence.* Contemporary practitioners generally borrow freely from all of these systemic approaches (hence, they are presented together in this chapter).

Step 3: Evaluate outcome and client response: After the intervention, the counselor assesses the client's response and uses this information to design the next intervention.

Step 4: Interrupt the new pattern: Then the counselor interrupts the new pattern with another intervention. This continues—interrupting behavioral sequence, allowing family to reorganize and respond, and intervening again—until the problem is resolved.

Who's Involved

When possible, systemic counselors prefer to begin counseling with the persons most significant to the identified client in attendance, often family or partner, to assess the relational system (Colapinto, 1991). Once the relational system has been assessed, the counselor may meet with specific subsystems and individuals to achieve particular goals. For example, often sessions with the couple alone are necessary to strengthen the boundaries between the couple and the parental subsystems and to sever cross-generational coalitions with children or in-laws. If seeing only an individual, the counselor still assesses the *entire relational system* as much as possible, often using *circular questions* (see "The Doing: Interventions") that trace how each person in the system responds to the other in situations involving the problem.

Making Connection: Counseling Relationship

Joining

Rather than thinking in terms of empathy, transference, or rapport, systemic counselors build relationships with clients by recognizing that they are *joining* a system that has its own distinct set of rules for communicating, showing respect, and making meaning (Minuchin, 1974; Minuchin & Fishman, 1981; Minuchin & Nichols, 1993). Rather than demonstrating understanding by verbally expressing empathy, systemic counselors "join" a system by accommodating to its style: how people talk, forms of emotional expression, pacing, and so on. In the historical context of mental health, this is a radical concept in that the counseling relationship accommodates to the client rather than the inverse, making it more adaptable to various cultural groups.

Much like an anthropologist observing and studying a new culture, systemic counselors approach clients with abundant curiosity about how they make meaning, organize their relationships, handle power, solve problems, express love, hang tough, entertain themselves, and otherwise move through life (Minuchin, 1974). The process of joining can also be likened to learning a new dance. Do they talk fast or slow? Do they talk over one another, or do they wait for clear pauses to speak? Do they use teasing and humor, or are their words gentle and soft? A successful systemic counselor needs to have a wide repertoire of social skills to successfully join with families, especially when working with diverse populations.

Respecting and Trusting the System

Systemic counselors respect the *system* of which the client is a part and view it as an entity that has its unique *epistemology* or way of knowing and understanding the world. Fully and humbly aware that they do not have direct control over a system, systemic counselors have an abiding trust that the system will reorganize itself in new and better ways without the counselor forcing the change. Instead, the counselor provides opportunities—sometimes many opportunities—for the system to reorganize itself, using various interventions that are designed not to be the "solution" for the client but rather to shake the system up and allow it to naturally resettle into its own solution. Symptoms

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are seen not as indicators of individual pathology but rather as the by-product of interactional sequences in relational systems that have served a purpose (if you are paying attention, you will notice I repeat this point because it is hard to grasp, taking years to fully appreciate the implications).

Neutrality and Multipartiality

As you can imagine, when counselors start working with more than one person in the room, they are invited many, many times both verbally and nonverbally to take sides: "Counselor [wink, wink] is it healthy, natural, or normal for a person to do or feel X?" Breathlessly, everyone in the room awaits your response to see whose side you will join. Answering this or other innocent-sounding questions typically leads down a painful, slippery slope and to the erosion of a good counseling relationship. All new counselors slip and slide several times before they finally learn, but at least you have been forewarned.

Knowing this, systemic counselors advocate a *neutral* stance when working with clients (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980; Selvini Palazzoli et al., 1978). Neutrality is practiced in two ways: *nonpartiality*, not taking sides on particular issues, and also *multipartiality*, the willingness to honor all perspectives. Cecchin (1987) of the Milan team emphasizes that neutrality applies to how the counselor relates to clients as well as problems.

Neutrality in Relation to Clients Cecchin described neutrality the *pragmatic effect* the counselor has on the client: if at the end of the session the client cannot say which "side" the counselor was on, then the counselor has had the pragmatic effect of being neutral. A counselor may appear to take sides with each person's view simply by discussing it, understanding it, and empathizing with it; thus, the key is for clients to leave without feeling the counselor is on anyone's side—or if the client's epistemology includes the view that the counselor *must* be on someone's side, the client is at least quite confused about whose that may be. This type of neutrality is even more important when working with individual clients because if a counselor gives the impression of literally being on the client's side, especially in terms of a relational dispute, the client will not be motivated to change and instead will more likely go home, tell the other that "my counselor says you are wrong" (reality check: even if you try very, very hard to be neutral, it is very likely that clients will do this anyway, but at the very least you should not encourage it; this is a form of triangulation discussed below).

Neutrality in Relation to the Problem More abstractly, counselor neutrality also implies not getting overly invested in particular meanings, descriptions, or outcomes (Boscolo, Cecchin, Hoffman, & Penn, 1987). The Milan team carefully avoided "falling in love with" (they were Italian and actually described it this way) any one description of the problem, *including their own*. Thus, neutrality also requires that the counselor not rigidly hold onto his or her own hypotheses and case conceptualization ideas: the case conceptualization should be constantly evolving and changing rather than rigidly remaining the same. Using a fluid problem description, the counselor has more maneuverability and can see more possibilities for intervention, instead of focusing on the single solution.

Maneuverability

Perhaps the most adaptable and flexible in terms of forming a working alliance, systemic counselors do not use a one-size-fits-all approach to developing the counseling relationship. Systemic counselors highly value *maneuverability*, the freedom to use personal judgment in defining the counseling relationship so that it is most likely to quickly effect change (Nardone & Watzlawick, 1993; Segal, 1991; Watzlawick et al., 1974). Depending on (a) the relational rules of the particular system and (b) the presenting problem, the counselor may play the role of an expert or may take a one-down helpless stance (see One-Down Stance), depending on which stance seems to help clients reach their goals more quickly, not on what the client simply prefers. Furthermore, the counselor

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may choose to be disliked by the client or be the "bad guy" in order to achieve the desired change in the system. Thus, in the working phase, the counselor may use different relational roles with different clients to promote change.

One-Down Stance

The one-down stance operates at two different levels: a general one-down stance in relation to the system and a strategic use of the one-down stance to promote change with certain clients (Segal, 1991). At one level, the one-down stance is sincere and genuine for systemically trained counselors, because they respect each system as an entity that has its owns rules and integrity that must be respected, much in the sense that a mountain climber must respect the awesome forces of nature or the sailor an ocean: there is no way to forcibly control or predict it; one can only defer to it and learn to gracefully and skillfully dance with its natural rhythms.

The second and more common use of the one-down stance refers to the counselor paradoxically claiming, "I'm not sure if I am able to handle such a problem" in order to motivate clients to change. Frequently used with clients who relentlessly complain that their situation is utterly hopeless yet do not take action, when the counselor *instead* takes the hopeless stance, the logic of the system impels the client to take up the role of being the hopeful one. Systemically, this works because in most systems there is a counterbalance where, if one person is hopeless, the other feels compelled to be hopeful to maintain a balance. This same dynamic is also observed between couples in crisis: generally, one person will manage the crisis, allowing the other one to more fully feel the panic and trauma in that moment.

Social Courtesy

One of the first advocates of using everyday conversation in counseling relationships, Haley (1987) describes the initial stage of counseling as the *social stage*, a time during which the counselor engages in casual social conversation (e.g., about the weather or traffic) as a way of making clients comfortable and reducing their sense of shame: "the model for this stage is the courtesy behavior one would use with guests in the home" (p. 15). Before moving on to discussing the problem, the counselor ensures that all members have been properly greeted. During the social stage, the counselor is assessing interactions and mood in order to know how to begin moving into discussing the problem (Haley & Richeport-Haley, 2007). Even a few moments of "normal" social conversation can help clients feel more empowered, connected, and engaged because the counseling relationship involves something familiar.

Spontaneity

Counseling spontaneity refers to the ability to flow naturally and authentically in a variety of contexts and situations, but it does not imply a throw-caution-to-the-wind and say-what-you-please approach. Instead, systemic spontaneity is a relationally and contextually responsive expression of self that is constrained by the relational rules of the system (Minuchin & Fishman, 1981, p. 3). Much the way driving a car becomes "natural" after years of practice, systemic spontaneity is cultivated and shaped through the training process, increasing counselors' repertoire for "being natural" in a wide range of clinical situations.

Observation Team

A trademark practice of systemic approaches, counselors work with an *observation team* to better observe systemic patterns (Watzlawick et al., 1974). This practice evolved from the Bateson team's early research methods where they would sit behind a one-way mirror to observe the "conductor of the session" working with the family. The team could "see" the systemic dance more rapidly and completely because the person in the room very quickly falls in sync with the family system and has a more difficult time seeing the entirety of the interaction. Anyone who has spent time behind a mirror and in front of it knows that you are always "smarter" behind it. The distance created by not being part of the interactional dance of the family increases one's ability to see the steps more

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clearly and quickly. Arguably the main reason that family counselors still train with a mirror is to develop the ability to "see" the systemic dynamics. This is never to say that a counselor in the room *can't* see the systemic dynamics; it is just harder and takes more practice.

The Viewing: Case Conceptualization and Assessment

Systemic counselors conceptualize work with individuals, couples, and families using the following concepts:

Areas of Systemic Case Conceptualization

1. Strengths and Development
   - Strengths
   - Family life cycle stage of development
2. Systemic Dynamics
   - Interactional patterns and behavioral sequences
   - Role of symptom in the relational system
3. Structure of the Relational System
   - Subsystems
   - Triangles and cross-generational coalitions
   - Boundaries
   - Hierarchy
   - Complementarity

Strengths

Systemic counselors are fundamentally *strengths-based*, keeping their focus on clients' strengths and advocating strongly against labeling families or individuals as "dysfunctional." In particular, systemic counselors focus on unique cultural and idiosyncratic strengths, such as religious beliefs or unusual hobbies, using these to design interventions (Minuchin & Fishman, 1981; Minuchin & Nichols, 1993; Watzlawick et al., 1974). Minuchin and Fishman (1981) powerfully argue against seeing the family as an enemy of its individual members, as is frequent in psychological literature, encouraging counselors to recognize how the family provides support, protection, and a foundation for its individual members. Family strengths are used to design interventions that promote the goals of individual and family growth, as well as reduce symptoms (see Chapter 16 for a full description of assessing strengths).

Family Life-Cycle Stage of Development

Rather than a static entity, the family is viewed as continually growing and changing in response to predictable stages of development and unexpected life events, such as a death, moving, or divorce (Carter & McGoldrick, 2005; Minuchin & Fishman, 1981). Successfully navigating each stage requires changes in how the family balances *interdependence* and *independence* to meet each person's changing developmental needs. Whether working with individuals or families, systemic counselors identify their stage in the life cycle to better understand their developmental needs and challenges. Although this cycle can look vastly different based on cultural norms and family structure, the typical cycle involves the following developmental tasks:

1. *Leaving home: Single adult:* Accepting emotional and financial responsibility for self.
2. *Marriage/committed partnership:* Committing to new system; realigning boundaries with family and friends.

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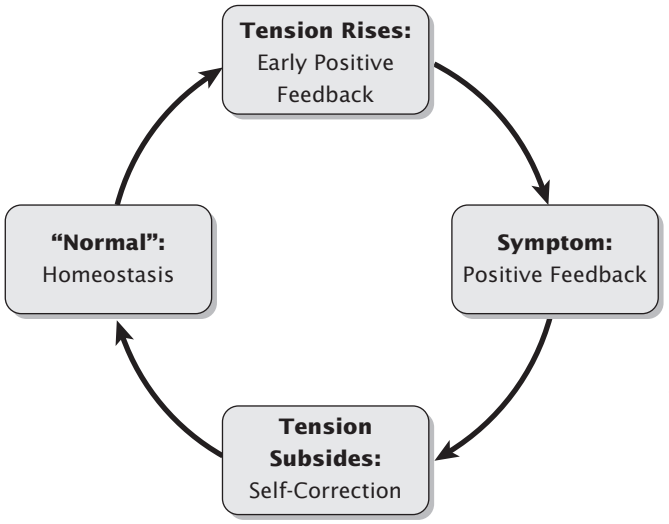
3. *Families with young children:* Adjusting marriage to make space for children; joining in child-rearing tasks; realigning boundaries with parents/grandparents.
4. *Families with adolescent children:* Adjusting parental boundaries to increase freedom and responsibility for adolescents; refocusing on marriage and career life.
5. *Launching children:* Renegotiating marital subsystem; developing adult-to-adult relationships with children; coping with aging parents.
6. *Family in later life:* Accepting the shift of generational roles; coping with loss of abilities; middle generation takes more central role; creating space for wisdom of the elderly.

Carter and McGoldrick (2005) also discuss alternative family life-cycle models for gays/lesbians, single adults, divorced families, single-parent families, and remarried families, all of which center around the fundamental tension of balancing a sense of connection with significant others while maintaining a sense of individuality. At each stage of the process, family members need to renegotiate boundaries to define levels of closeness and independence that support the growth needs of individual members. Families often get stuck transitioning from one stage to another if they fail to renegotiate boundaries and hierarchy as the family develops. For example, after the birth of a child, couples need to radically reorganize how they manage independence and interdependence as they add the high-maintenance needs of a newborn into their juggling act. On the other end of the spectrum, as in the case study at the end of this chapter, Navid's family is adjusting to his leaving for college and establishing himself as a responsible adult, which he is not doing as well as the parents expected. His parents step in, using authoritarian rules to try and force Navid to stop smoking pot, thus delaying the need to reorganize the system and adapt to his launching.

Interaction Patterns and Behavioral Sequences

Of critical importance when working with individuals who do not have others to share the "other side of the story," systemic counselors always assess the *interaction patterns* and *behavioral sequences* surrounding a symptom. Assessing interaction patterns involves tracing the behavioral sequences in the homeostatic dance in which the symptom is embedded. The interactional sequence is traced through four general phases: (a) things being normal (homeostasis), (b) tensions escalating (early positive feedback), (c) the symptomatic feelings and behaviors (positive feedback), and, finally, (d) self-correction with the ultimate return to normal (homeostasis). Depending on the symptom, this sequence can take several minutes or several months. Clients typically only describe the symptom, but by tracing the symptom from homeostasis to homeostasis, systemic counselors have a much better sense of how to intervene.



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For example, if a client complains that she is anxious in public situations, a systemic counselor would explore the behaviors and interactions when the client feels "okay" or normal, and then identify the behaviors, contexts, and relational interactions when the anxiety starts to rise, what she does when she feels the anxiety at its height, and how others respond, and then trace the behaviors and interactions until she feels "okay" or back to normal again. Similarly, when working with a couple who argues, the counselor first asks about what types of things they are doing when things are good between the two of them, what each starts to do as tensions rise, what each says and does in response to the other during the argument, and how they get back to a sense of "normal" again.

In addition to observing actual interactions, systemic counselors *ask* a series of questions to assess the interaction sequence. For example, with the couple having trouble with the defiant child, in addition to observing, the counselor would ask, What is happening just before the problem incident? What is each person saying and doing? How does the child respond? How does each parent and anyone else involved respond to the defiance? How does the child respond to this?

Questions for Assessing Interactional Sequence

- *Counselor asks about "life as normal" related to the presenting issue.*
  Example: "What is going on when you feel normal (okay, good, etc.)?"
- *Counselor asks client to describe how the problem begins, inquiring about contexts and persons that seem to trigger the symptom if these are not obvious.*
  Example: "Describe what typically happens prior to feeling anxiety. Then how does the anxiety ultimately begin? Does it seem to happen in particular contexts or with certain people?"
- *Counselor inquires about the behavioral sequence that comprises the symptom.*
  Example: "So what do you do at the height of the anxiety? What type of dialogue is going on in your head? How do others respond to you? How do you respond to them? What happens next?"
- *Counselor continues to trace these back-and-forth interactional patterns until things return to "normal" or homeostasis.*
  Example: "How do things get back to normal? Do you have to do something? Does someone say or do something that helps? Does it generally happen the same way every time?"
- *Counselor also inquires about how significant others in the system respond to the problems situation.*
  Example: "Are others affected by this anxiety? How do they respond during or afterward? How do you respond to them?"
- *Counselor continues assessing the interaction pattern until it is clear that the entire system has returned to its sense of "normalcy."*

Try It Yourself

Find a partner and use the above questions to assess the interactional sequence for a relational problem.

Role of the Symptom

Systemic counselors view symptoms as playing a role in maintaining relational homeostasis and a sense of normalcy (Colapinto, 1991). Symptoms can help maintain a sense of normalcy in a number of ways: limiting emotional intimacy, creating physical distance, forcing connection, creating distraction, or delaying developmental changes, just to name a few. Even though the symptoms are unwanted, they are often preventing or minimizing an even more distressing situation. For example, fear of going to public places (agoraphobia) often serves to force connection with a select few while creating great distance from

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others and avoiding numerous other responsibilities. Systemic counselors never view the *symptom bearer* or *identified patient* as the sole source of intervention, and instead the family interaction patterns are targeted for intervention. In the case study at the end of this chapter, Navid's substance use is considered as part of the family's homeostasis, helping to maintain his dependent status and his parents' caretaking roles.

Subsystems

Using Minuchin's (1974) structural theory, systemic counselors conceptualize a family as a single system that consists of multiple *subsystems*. Certain subsystems exist in all families: couple, parental, sibling, and each individual as a separate subsystem. In addition, in some families other influential subsystems develop along gender lines, hobbies, and interests (e.g., sports, music, etc.), and even personality style (e.g., serious versus fun-loving). When assessing a client's family (also see Chapter 16), the most important subsystem issues to consider are the following:

- Is there a clear distinction between the *parental* and *couple* subsystems?
- Is there a clear boundary between the *parental* and *child* subsystems? Alternatively stated, is there an effective *parental hierarchy*?
- Is the family divided along subsystem lines?

Many couples need help distinguishing the marital from parental subsystem when all their energy goes into caring for the children with nothing left for the relationship. Frequently, parents need help distinguishing the parental and child subsystems by establishing a hierarchy (see "Hierarchy"). Additionally, many subsystems create unhelpful dynamics that need correcting, such as coalitions across generations.

Triangles and Cross-Generational Coalitions

One type of subsystem is particularly damaging: *triangles* (Bowen, 1985), which often take the form of *cross-generational coalitions* (Minuchin & Fishman, 1991; Minuchin & Nichols, 1993). Triangles can form in any relationship in which a third person is pulled in to reduce tension in a dyad, often taking the form of "confiding" in a friend or family member who takes the side of one person in the dyad against the other. Cross-generational coalitions are a *triangle* that forms between a parent and child *against* the other parent or other key caretaker. This is a common family dynamic, often involving a parent who "teams up" with one or more children against the other parent, undermining the other parent, taking the child's side in an argument, using the child as a confidante, or simply being more invested in the parent–child relationship. In a divorce, this pattern is almost universal as parents vie to create coalitions against the other. Triangles can be *overt*, readily identifiable, or *covert*, not directly addressed or spoken about in the family but evident by secrets between the parent and child ("Don't tell your mom/dad about this") or comments that compliment the child and disparage the other spouse ("I am so glad you didn't inherit your father's/mother's gene for X").

Boundaries

"*Boundaries*" refer to the relational patterns and rules for relating in a system. Each individual family has a unique set of boundaries that are closely tied to their family, cultural, socioeconomic, gender, educational, and other background variables. When initially assessing boundaries, they seem two-dimensional: too weak or too strong. But the more you work with them, the more you learn that they are far more complex than they appear at first glance. Nonetheless, let's start with the simple two-dimensional definition.

Boundaries are rules for managing physical and psychological distance between family members, defining the regulation of closeness, distance, hierarchy, and family roles (Minuchin & Fishman, 1981). Although they may sound static, they are an organic, living process. Systemic counselors identify three basic types of boundaries:

- *Clear boundaries:* Clear boundaries refer to a range of "normal" boundaries that allow for close emotional contact with others while also allowing each person to maintain a sense of clear identity (Colapinto, 1991). Each culture defines a range of

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"normal" boundaries that define appropriate expressions and levels of independence versus interdependence. For example, in some cultures, more physical space is typical of clear boundaries than others, and within a given culture, families can have a wide variety of expressions of this that are considered normal. Import those same rules to another culture (e.g., from anywhere to the United States), and the once-normal boundaries may not be "normal" in the new context. Thus, immigrant and multiracial families have much more complex boundary dynamics to navigate the multiple worlds in which they live.

- *Enmeshment and diffuse boundaries:* If boundaries are blurry, diffuse, or weak, this leads to relational *enmeshment*, which is evidenced by a lack of clear distinction between members and a strong sense of mutuality and connection at the expense of individual autonomy (Colapinto, 1991). When talking with an enmeshed family, counselors typically see family members do the following:
  - Interrupting one another and/or speaking for one another
  - Mind reading and making assumptions
  - Insisting on high levels of protectiveness and overconcern
  - Demanding loyalty at the expense of individual needs
  - Feeling threatened when there is disagreement or difference

  How do you sort through family and cultural differences and determine whether a particular relationship has clear or enmeshed boundaries? Simple. If there are symptoms and problems in one or more individuals and/or complaints about family interactions, then the boundaries are too diffuse for the current developmental stage and context. Thus, behaviors that constitute problematic boundaries in one cultural context may be clear in another cultural context, making it difficult for families and counselors alike to sort out relational rules in immigrant and other bicultural families because there is more than one cultural context at play (Minuchin & Fishman, 1981). Counselors must proceed slowly and mindfully to accurately assess where and how boundaries are a problem, to avoid inadvertently imposing dominant cultural norms or psychological theory on clients. That said, rarely in the early stages of counseling are boundaries clear, because generally some boundary patterns need to be renegotiated to resolve the presenting complaint.
- *Disengagement and rigid boundaries:* Boundaries can also become highly rigid, resulting in relational *disengagement*. Families with rigid boundaries value autonomy and independence over emotional connection, creating isolation that may be more emotional than physical (Colapinto, 1991). These families have excessive tolerance for deviation, often failing to mobilize support and protection for one another. Counselors working with disengaged families notice the following:
  - A lack of reaction and repercussions, even to problems
  - Significant freedom for most members to do as they please
  - Few demands for or expressions of loyalty, affection, or commitment
  - Parallel interactions (e.g., doing different activities in the same room) consistently substituting for reciprocal interactions and engagement

  Like enmeshed boundaries, rigid boundaries cannot be accurately assessed without taking cultural and developmental variables into consideration. High levels of independence are not considered problematic unless one or more persons are experiencing symptoms.

Hierarchy

A painful, shocking reality that I was very slow to believe as a new counselor is that most child behavior issues boil down to an ineffective *parental hierarchy*—or at least the issues greatly improve when hierarchical issues are addressed. The parental hierarchy refers to the power differential between the parent and child and the parent's ability to

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manage the child's behavior (Colapinto, 1991; Minuchin, 1974; Minuchin & Fishman, 1981). There are three basic forms of parental hierarchy:

- *Effective:* An effective parental hierarchy is evidenced by two things: (a) parents can effectively set boundaries and limits while (b) still maintaining emotional connection with their children. For better or worse, children keep changing, and thus the behaviors that constitute an effective parental hierarchy at one point in time do not work at another—thus, it is hard for parents to continually shift and balance these two roles as children grow.
- *Insufficient:* A common parenting pattern, an insufficient parental hierarchy means that the parent is not able to effectively manage the child's behavior, commonly referred to as a permissive parenting style. In these families, parents cannot sufficiently influence their children's behavior to avoid problems from erupting. Often these parents hope that the counselor will "teach" their children to obey rules, be polite, and take responsibility. Alas, such a hope is in vain. Each adult must establish an effective hierarchy with a child on a one-to-one basis: this includes parents, teachers, stepparents, and, yes, counselors, too. In fact, it is commonly the case that one parent has an effective hierarchy and the other does not, thus providing evidence that the burden is on the adult rather than the child to effectively establish a hierarchy. Similar to boundaries, the outward expression of an effective versus an insufficient hierarchy can be determined only by examining the cultural context, family life stage of development, and symptomatic behavior.
- *Excessive:* The other extreme is an excessive hierarchy in which the parent maintains rules that are developmentally too strict and unrealistic and consequences that are too severe to be effective. The children typically behave well (until they decide to rebel) but at the expense of emotional closeness. These parents need assistance in developing age-appropriate rules and expectations and in developing a stronger emotional bond with their children.

Complementarity

One of the more subtle areas assessed by systemic counselors, "complementarity" refers to rigidly adopted patterns of opposite roles in a relational system (Colapinto, 1991). Like jigsaw puzzles, individuals develop complementary roles in their couple, family, and organizational relationships: the over-/underfunctioner, good/bad child, understanding/strict parent, logical/emotional, role model/rebel, and so on. Over time, these systemically generated roles become viewed as inherent personality characteristics that seem unchangeable within that particular relationship, even if the same dynamic is not manifested in other contexts. The more exaggerated and rigid these roles become, the more of a problem they create. After years, the individuals involved do not believe they could behave any differently, although they have ample evidence that they did in fact possess these qualities prior to being in the relationship. One of the most distinguishing features of systemic counselors is that they are able to recognize rigid complementary patterns as part of the system dynamics, rather than individual personalities, and can help clients move beyond them.

Targeting Change: Goal Setting

Four Steps for Setting Systemic Goals

In the MRI brief approach, counselors use a four-step process for setting goals based on the axiom that "the problem is the attempted solution," meaning that the problem is that the client has been using the wrong class or type of solution (Watzlawick et al., 1974). The counselor's task then is to identify the type of solution that *hasn't been working* and then identify what solutions would represent a solution that uses an alternative logic or premise. For example, if a person is trying to reduce worry by trying to control or manage it—and all those attempts have failed—the counselor would identify solutions with an alternative logic to control, such as indulging the worry by instructing

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the client to worry at specific times (see the section "Paradoxical Intervention and Symptom Prescription").

Setting systemic goals involves four distinct steps:

Step 1: Clearly define the problem: Define the problem in concrete, behavioral terms, including the actions and reactions of all involved: When a systemic counselor hears from a client, "I worry too much," the counselor has not really heard a meaningful problem statement. The counselor's job at this point is to help the client turn this into a clear problem statement that is behavioral and concrete: "When I am assigned an important project at work, I end up thinking about it before I go to bed, during my commute, and when working on other projects; I ask my boss a thousand questions and she gets annoyed with me; I second-guess myself when talking with my partner at dinner, and she keeps trying to reassure me that I am doing great, but I don't believe her because she is just saying that to make me feel better." Now *that* is a clear problem.

Step 2: Identify prior attempted solutions: Identify the attempted solutions thus far: The counselor may ask, "How have you attempted to deal with this problem?" and listens for patterns in the various attempted solutions (e.g., I tell myself to stop worrying but can't stop; I look to others to reassure me but don't believe them either; etc.). Although a seemingly obvious thing to assess, attempted but failed solutions often are not spontaneously mentioned because they are typically not remembered or flagged as important because they didn't work.

Step 3: Develop a clear description of preferred change: Develop a behavioral description of the things to be changed: Systemic counselors take goal writing very seriously. *How* the goal is languaged is a critical part of the intervention. If systemic goals are not crafted carefully, using clear descriptions of *behavioral change*, failure is more likely. Watzlawick et al. (1974) identify three characteristics of helpful goals: realistic, specific, and time-limited:

- *Realistic:* Systemic counselors avoid pie-in-the-sky, utopian goals that clients hope they can achieve by seeking professional help, such as *always* be happy, *never* fight with a partner, or have a child who *always* obeys. If humans are involved, "always" and "never" are not a part of realistic goals. Instead, he counselor helps the client develop more human goals that "increase the frequency" of desired behaviors and decrease that of undesirable ones. For many clients, accepting realistic goals is a significant form of change in and of itself, often resulting in improvements just from setting a realistic goal.
- *Specific:* Goals should target clearly defined behaviors and interactions rather than vague intentions, such as "communicate better," "feel happier," or "relax more." Vague goals can set up false hopes and reduce the counselor's effectiveness. Instead, goals should be written so it is easy to determine when they have been attained: "increase frequency of asserting needs at work" or "increase time spent with friends."
- *Time-limited:* Systemic counselors set clear time limits (e.g., achieve goal in four weeks or four months) to help motivate and focus both client and counselor.

  A written time limit helps set realistic expectations. When time limits are not met, systemic counselors view this as feedback indicating that something may be amiss and needs to be addressed, such as an unassessed dynamic, an inadequately joined counseling system, poorly designed interventions, or unrealistic initial goals.

Step 4: Develop a systemic treatment plan: Develop a plan that is based on systemic principles to achieve change: When developing a plan, systemic counselors use two basic principles:

- The *target of change* is the *attempted solution*, meaning that a new logical premise is used (e.g., rather than forcefully trying to control a behavior, the new logic is to allow it in some form).

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- The *tactic of change* is to use the *client's own language* to speak directly to the client's view of reality (e.g., if the client is athletically inclined, a sports metaphor may be used).

When designing a treatment plan, systemic counselors *never* use commonsense logic or basic psychoeducation on how to solve problems: that is the type of approach used in cognitive-behavioral or Adlerian counseling. Instead, systemic counselors alter the interaction pattern, trusting that the system will reorganize itself using its innate ability to self-correct—the counselor's role is simply to give the system a gentle nudge in the right direction, which is in the *opposite* direction of the prior attempted solution.

Systemic and Structural Goals

Systemic counselors target similar basic goals for clients that can generally be categorized as goals for (a) systemic dynamics and (b) family structure (Colapinto, 1991; Madanes, 1991; Minuchin, 1974; Watzlawick et al., 1974).

General Goals for Systemic Dynamics

- Develop relational patterns that maintain *flexible interaction and behavior patterns* without the presenting symptom(s)
  Example: Reduce pursuer-distancer pattern and increase ability to tolerate higher levels of intimacy

General Goals for Family Structure

- *Clear boundaries* between all subsystems that allow for *intimacy* and *individuation* appropriate within client's cultural contexts
  Example: Reduce enmeshment between client and mother to increase client's ability to make independent decisions
- Clear distinction between the *marital/couple subsystem* and *parental subsystem* (if children are involved)
  Example: Increase separation of parental and marital subsystems to increase emotional intimacy and solidarity in the partnership
- *Effective parental hierarchy* and the severing of cross-generational coalitions (if children are involved)
  Example: Increase the effectiveness of the parental hierarchy and the ability of the parents to consistently set and reinforce limits
- Relational structures that promote the *development and growth of individuals and relationships*
  Example: Increase sense of emotional connection with father

The Doing: Interventions

Enactments and Modifying Interactions (see "The Juice")
Systemic Reframing

One of the most frequently used interventions, systemic counselors use *systemic reframing* to alter interaction and behavior patterns related to the problem by offering new frameworks for viewing the problem (Colapinto, 1991; Minuchin, 1974; Minuchin & Fishman, 1981; Watzlawick et al., 1974). Systemic counselors reframe problems in a very specific way, which distinguishes their work from other forms of counseling. Specifically, *systemic reframes illuminate how a client's symptom is part of a larger interactional pattern.* For example, if a person's worrying elicits sympathy from others, creating a sense of connection, a systemic reframe would highlight this dynamic in the reframe.

Systemic reframing focuses on reciprocal interactions, meaning that person A affects person B's response, which then affects person A's response, which affects B's response, ad infinitum (A ⇆ B). This process requires piecing together the interaction patterns that involve the client and others involved in the problem interaction sequence, and reframing each person's behavior—particularly the symptom—so that the broader systemic dynamic is revealed.

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How to Generate Systemic Reframes

1. *Assess broader interactional patterns:* Complementary relationships, hierarchy, boundaries, and so on.
   Example: The counselor assesses a hero/damsel-in-distress pattern in which a woman's husband responds to her fear of a manic episode relapse by taking over many of her household tasks and chores; the more he does, the less capable she seemingly becomes.
2. *Redescribe the problem in a systemic frame:* Use interactional pattern to describe problem in larger context.
   Example: The counselor can reframe the situation thusly: "Your fear and your husband's fear of relapse has resulted in him taking over many of the household tasks you dislike: cooking, cleaning, doing homework with the children, paying bills, and so on. Now you are in a situation where you have to stay worried about relapse in order to avoid those tasks. It's a tough situation you are in. If you allow yourself to feel better, you have new problems to deal with."

Circular Questions

In my humble estimation, circular questions are some of the best questions in the field of mental health because they have a consistent one-two punch: assessment and intervention. They are invaluable when working with clients who complain about or compare themselves to others (okay, I guess that covers virtually all of us). Developed by the Milan team, circular questioning is an elegant and highly efficient technique that simultaneously assesses interactional patterns while reframing them: thus, this is a winning two-for-one assessment/intervention combination. Circular questions make overt the systemic dynamics and interactive patterns in the system, and by doing so they inherently *reframe* the problem for all participants without the counselor directly proposing a reframe (Selvini Palazzoli et al., 1978, 1980). They are perhaps the most effective way means of "confronting" clients on patterns that they don't want to acknowledge without the counselor having to directly confront: instead, *the clients* are the ones who reveal the pattern by responding to questions. It's always harder to not believe oneself than another.

Specific forms of circular questions (Cecchin, 1987) include the following:

- *Behavioral sequences questions:* These questions trace the entire sequence of behaviors that constitute the problem, such as "When you start to get depressed, what is your first sign? What do you do next? What do others see and how do they respond? How do you respond in turn to them? What happens next?" The counselor follows the sequence of interactions until homeostasis is restored again.
- *Behavioral difference questions:* Behavioral difference questions shatter the illusion that a particular behavior is part of a person's inherent personality. For example, if a client claims, "I am a worrier," the counselor would ask, "What do you do that makes you a worrier?" The *behavioral definition* of the problem behavior, "plan for how to handle potential problems," is then used to compare with others: "How does your partner plan for potential problems? How did your parents plan for potential problems? Others that you know? What is similar and what is different about these approaches?"
- *Comparison and ranking questions:* Comparison and ranking questions reduce labeling and other rigid descriptions of self and others; they also help illuminate problem interaction patterns: "Who is the most anxious person you know (or in your family, office, etc.)? The least anxious? How does each deal with anxiety? Who is the most upset by your anxiety? The least upset by it?"
- *Before-and-after questions:* When a particularly notable positive or negative event has occurred, counselors use "before" and "after" questions to assess nuances in the relational dynamics: "Before your depressive episode, did you and your partner fight more or less? Who was happier at that time? Who did more of the chores then?"

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- *Hypothetical circular questions:* Hypothetical questions can be helpful in assessing how a person responds to stress and to better understand the subtle relational dynamics. For example, "If you were to suddenly lose your job, what would you do? Who would you turn to first? Who would be the first to offer help? Who would you not want to tell?"

In the case study at the end of this chapter, the counselor uses circular questions to enable Navid to better see how his substance use is related to the family dynamics and, rather than a form of "rebellion," his behavior is actually serving to keep the family functioning the same, namely, with his parents treating him like a child.

Try It Yourself

Find a partner and take turns asking circular questions related to a current life problem. In what ways do these questions change how you view or define the problem?

Directives

Frequently misunderstood because they do not follow commonsense logic, directives are a signature systemic technique (Madanes, 1991). As the name implies, directives are directions for the client to complete a specific task, usually between sessions but sometimes within the session. The key element is that the tasks are rarely "logical" or linear solutions to the problem; instead, they interrupt the system's interaction patterns in minor but meaningful ways to create new interactions (Haley, 1987). More simply stated, they are designed to "trip up" the problem and get the pattern slightly off-kilter so that clients have to rebalance. Systemic counselors trip up the problem with the *smallest change possible*. For example, if part of a client's "depression ritual" (or pattern) involves eating a pint of his favorite ice cream, a directive might involve tripping this pattern up with the least amount of change (client more likely to do it) that is still meaningful (shakes things up): such a directive might be to read a favorite poem aloud or eat a pint of a less desirable flavor, such as strawberry. Although this may sound quite ridiculous at first, for the person involved, just shifting that one element often results in "waking up" and seeing the pattern more clearly and also feeling more motivated to do something different. Because they are based in action, directives inspire a visceral form of insight because the person is in the middle of the action that needs changing, which is quite different from the more distant, cognitive insight in traditional psychodynamic theory.

Designing Directives

Step 1: Assess *the problem sequence of behaviors:* Identify the sequence of behaviors that constitute the presenting problem (e.g., client encounters problems with a project at work, becomes intensely focused on project, or is snippy with coworkers and ignores family; when work problem is solved, client is happy but has alienated people in his life).

Step 2: Target a small change in behavioral sequence: Identify one small behavioral change in the sequence that the client can reasonably make that would alter the problem sequence (e.g., put on an object of clothing, hang a sign, or otherwise send a signal to others that symbolizes he is unavailable for normal human interaction until the problem is resolved).

Step 3: Motivate the client to follow through: Haley (1987) emphasizes the importance of motivating the client *before* the task is issued. This is usually done by appealing to the ultimate goal: that the client and significant others wants the problem behavior to stop.

Step 4: Give precise, doable instructions for the directive: The key to directives is to be very specific: what, where, how, who, and on which day of the week. The counselor should consider variations in schedules, such as vacations, illness, weekends,

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and so on. Furthermore, the directives should be *given* rather than casually suggested. For example, "It sounds like you would really like to do something different the next time you get pulled into a work project. So here is what I want you to do. The next time you start to feel the 'pull,' I want you to email your coworkers and family that you will unfortunately be absent in their lives until this problem is resolved. Feel free to add playful references to your metaphoric death, by perhaps signing it, 'Temporarily departed.'" The counselor avoids theoretical or logical explanations about "why" and "what for" and simply says, "I think this might be helpful" if the client asks.

Step 5: Review the task in painful detail: Have the client describe precisely what he is to do and how he is going to do it (e.g., "Just to review and make sure we understand, can you review what you are going to do this week when you feel the pull of a project?").

Step 6: Request a task report: The following week, the counselor asks the client "how it went." Generally, one of three things happens: the client (a) does it, (b) does not do it, or (c) or partially does it (Haley, 1987). Obviously, if clients complete their tasks, they are congratulated, and the counselor discusses how it went. If they have partially done the task, the counselor does not excuse them too quickly because that would send the message that undermines the counselor's authority. If they fail to attempt the task, Haley uses two responses, one nice and one not so nice. In the nice way, the counselor says, "I must have misunderstood you or your situation to ask that of you—otherwise you would have done it" (Haley, 1987, p. 71). In the not-so-nice approach, the counselor emphasizes that the client has missed an opportunity to make changes for their own good and that this is a loss for him or her (*not* that the counselor is disappointed); the counselor does not ask them to redo the task even if they say they want to. Instead, the counselor uses this experience to increase motivation for the next task.

Paradoxical Intervention and Symptom Prescription

Perhaps the most misunderstood of systemic interventions, *paradoxical intervention* and *symptom prescription* involve instructing clients to engage in the problem behavior in some fashion, such as assigning a client to worry each morning from 8:00 to 8:15. Symptom prescription and other paradoxical interventions are "paradoxical" because they seem as though they will make the problem worse rather than better—or at least at first glance. I guess I should mention that, yes, indeed, they can make things worse if they are used at the wrong time or for the wrong problem, so these should be used only under careful supervision until you understand how they work.

You will know when it is time to use one of these interventions because *when it is appropriate to use paradox, it will not seem paradoxical—at least in the mind of the counselor—it will be the only logical, obvious action to take.* Generally, it takes many years of practice (and good supervision) until paradox seems like a good idea. Not a garden-variety technique that works for everybody, paradoxical interventions are appropriate for two types of problems: (a) when making any other change disrupts the client's current level of stability or (b) when the problem seems "uncontrollable" from the client's perspective: "I can't keep myself from worrying, nagging, eating, fighting, dancing a jig, and so on."

Paradox with Clients Resisting Change Some clients seem to resist any and all attempts at change even though they say they really, really want to change (the "really, really" part should be your first clue that things may not go as planned). No matter how great the idea and how much these clients agree to it, they never seem to follow through on anything that actually would promote change. As maddening as they can be for the counselor, these clients are not bad, hypocritical, or actively resisting. They simply need an intervention that honors the fact that this symptom is very important in maintaining homeostasis for them. Thus, they fear—often realistically—that giving it up may create *more* discomfort and chaos than they are currently experiencing; in these situations,

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paradox can be useful (Haley, 1987). In such a situation, the counselor may restrain or caution against certain changes, such as "perhaps the couple needs to argue to keep their passion strong; if they stopped, things may get worse." Paradoxical tasks are difficult to effectively deliver because the counselor must communicate several messages at once:

- I want to help you resolve your problem.
- I am sincerely concerned about you.
- I think you can be normal but perhaps you cannot.

When paradox is successful, change is usually spontaneous. Systemic counselors also often use paradoxical intervention in the later stages of counseling to prevent relapse by paradoxically encouraging it (Haley, 1976): "I know that you are saying that you aren't worrying anymore, but now I am a bit worried about that. You might just want to let yourself worry for five to ten minutes a day a few times a week, just in case you find that it really did solve problems for you."

Paradox with "Uncontrollable" Symptoms When clients report symptoms they claim to have no control over, systemic counselors use *symptom prescription* as an intervention. Symptom prescription changes the *context* (where, when, who, and what) of the problem behavior without requiring clients to stop having the symptom. If the context changes, the *meaning* of the behavior must also change. When the meaning changes, thoughts, feelings, and subsequent behaviors automatically change, too. A common example of using paradox is worrying, which is particularly difficult to intervene on because it is a thought and emotional process, often with limited associated behaviors. When a client is given the directive to set an egg timer to worry for ten minutes at a particular time in the day, it radically changes worrying from a vague, free-floating experience to a consciously chosen activity that they can voluntarily start and that most often they quickly discover they can also stop at will. By changing the context, the meaning and experience of worrying changes, often creating significant movement on a symptom that seemed totally out of the client's control.

Shifting Epistemologies: Expanding and Challenging the Client's Worldview

Systemic counselors carefully examine the rules, logic, and premises that clients construct their worldviews on: what is "necessary," what is prohibited, how does one show love, and what does one owe to others. Most people cannot list the majority of these epistemological assumptions that inform their every action, interaction, thought, priority, and emotion. By identifying and commenting on them, systemic counselors affect the operating premises that fuel the problem (Colapinto, 1991; Minuchin, 1974; Minuchin & Fishman, 1981).

As you might have guessed this far into the chapter, systemic counselors generally don't directly confront these premises but instead use existing beliefs and *expand* and *reinterpret* them in more helpful directions. Again, this intervention involves using the symptom—not asking clients to relinquish it—and recontextualizing, stretching, and/or reordering it to resolve issues. For example, if a client tends to be a perfectionist who never stops to enjoy life, you might help them become perfect at relaxing. Alternatively, if parents were great at structuring and setting limits with young children and start to struggle with teens, they can be challenged to learn how to get the teen to structure himself or herself and set his or her own behavioral standards. Like a martial artist, the systemic counselor takes a fundamental premise that has been supporting the problem and redirects its logic to support an alternative set of behaviors and interactions, allowing clients to maintain their core beliefs but use them in new ways.

Complimenting Strengths and Shaping Competence

Complimenting strengths and *shaping competence* are used to augment and reinforce the clients' natural positive interaction patterns and strengths. When systemic counselors

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identify client strengths, they are quick to compliment and encourage. A similar process, *shaping competence* involves noticing and complimenting small successes along the way to reaching goals. For example, if a client was able to stop a panic attack once during the week or keep it from getting out of control, systemic counselors compliment and encourage the client for these small successes.

Shaping competence also refers to not overfunctioning for the client, meaning doing things that the client is capable of doing and/or needs to be learning to resolve an issue. This can include setting limits with a child, jotting down an idea from session, following up on a phone call, or making a decision about how to proceed. Depending on a client's presenting problem, all of these common in-session occurrences are opportunities for clients to shape their competence rather than have the counselor do it for them, depriving them of an opportunity to learn in a safe and supported environment. In the case study at the end of this chapter, the counselor helps shape Navid's competence by complimenting his behaviors and decisions that include taking responsibility and avoiding trouble, such as choosing not to use and to focus on his studies.

Interventions for Specific Problems

Invariant Prescription to Sever Coalitions

As the name implies, the *invariant prescription* is a directive that is not varied across families because this one task quickly severs inappropriate parent-child coalitions (Selvini Palazzoli, 1988). The prescription is essentially this: the parents are instructed to arrange to go on a date (or other outing), and they are not to tell the children where they are going or why. The desired effect is to create a *secret* between the parents, ending inappropriate coalitions by creating a clear boundary between the parents as a unified team and the symptomatic child. The child loses the status of being a special confidante of the one parent, which also lessens the emotional burden on the child, resulting in fewer problem symptoms. Although originally designed for severe pathology such as anorexia or psychosis in the child, this intervention is also effective with parents who overemphasize transparent and open communication with their children to the extent that one parent creates a coalition with the child and/or the parental hierarchy is ineffective.

Ordeals for Compulsive Behaviors

Inspired by the work of Milton Erickson (see Chapter 12), *ordeals* are often used in situations where the client feels helpless in controlling a symptom, such as overeating, smoking, nail biting, drinking, and so on, and is based on a simple premise: "If one makes it more difficult for a person to have a symptom than to give it up, the person will give up the symptom" (Haley, 1984, p. 5). Rather than try to develop linear, logical means for stopping the behavior (that would be a cognitive-behavioral approach), the strategic counselor *allows* the symptom with a twist (by now, you should recognize this theme): the client must complete another task, an "ordeal" first or afterward.

The ordeal need not be directly related to the undesired activity but often carries a metaphoric relation to it. For example, if a person were trying to reduce his or her "emotional eating" to soothe difficult emotions, the ordeal would target the behavior and internal tension by logical means (e.g., write for ten minutes in a journal, jog for ten minutes, do a calorie log before the binge, etc.) or metaphorically (e.g., "clean out" the refrigerator, pantry, etc.; set an elaborate table for a feast) or with a seemingly unrelated task (e.g., perform a random act of kindness for a stranger or loved one, answer three emails, etc.). In most cases, ordeals are less about creating a horrific, unappealing ordeal to stop undesired behavior and more about shaking up or perturbing the systemic pattern so that new behavioral sequences can evolve. The ordeal isn't a behavioral deterrent or punishment as much as it is adding a new—often neutral—behavior that forces clients to interrupt their patterns. As the individual or family adjusts to this rather small and innocuous twist, it *must* change to create new steps and is able to do so with less fear and resistance than if it were told to stop.

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Boundary Making to Increase or Decrease Engagement

Boundary making is a special form of enactment that targets over- or underinvolvement to help families soften rigid boundaries or strengthen diffuse boundaries (Colapinto, 1991; Minuchin, 1974). Systemic counselors use this technique to direct who participates and how. By actively setting boundaries, counselors interrupt the habitual interaction patterns, allowing members to experience underutilized skills and abilities. Boundary making may involve several different directives:

- Asking family members to change seats.
- Asking family members to move seats farther apart or closer together or turned toward one another.
- Having separate sessions with individuals or subsystems to strengthen subsystem boundaries.
- Asking one or more members to remain silent during an interaction.
- Asking questions that highlight a problem boundary area (e.g., "Do you always answer for your son when he is asked a question?").
- Blocking interruptions or encouraging pauses for less dominant persons to speak.

Putting It All Together: Systemic Treatment Plan Case Conceptualization and Treatment Plan Templates

Theory-Specific Case Conceptualization: Systemic

Use the prompts below to develop a theory-specific case conceptualization; the case study at the end of the chapter provides an example.

- *Strengths:* Describe individual and family strengths
- *Family Life Cycle Stage:* Describe stage of family life cycle and significant struggles related to balancing independence with interdependence:
  - Single adult
  - Marriage
  - Family with young children
  - Family with adolescent children
  - Launching children
  - Later life
- *Boundaries:* Describe boundaries (enmeshed, disengaged, clear) with significant persons in client's life, including:
  - *Parents*
  - *Siblings*
  - *Significant other*
  - *Children*
  - *Extended family*
  - *Friends*
- *Triangles/Coalitions:* Describe significant triangles and coalitions
- *Hierarchy:* Describe hierarchies (effective, permissive, rigid, inconsistent) with children and/or parents
- *Complementary patterns*: Describe complementary patterns in relationships, such as:
  - Pursuer/distancer
  - Over-/underfunctioner
  - Emotional/logical
  - Good/bad parent
- *Intergenerational Patterns:* Describe significant intergeneration patterns:
  - Family strengths
  - Substance/alcohol abuse

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- Sexual/physical/emotional abuse
- Parent/child relations
- Physical/mental disorders
- Historical incidents of presenting problem

Treatment Plan Template: Systemic

Use this treatment plan template for developing a plan for clients with depressive, anxious, or compulsive types of presenting problems. Depending on the specific client, presenting problem, and clinical context, the goals and interventions in this template may need to be modified only slightly or significantly; you are encouraged to significantly revise the plan as needed. For the plan to be useful, goals and techniques should be written to target specific beliefs, behaviors, and emotions that the client is experiencing. The more specific, the more useful it will be to you.

Treatment Plan

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration:* [Describe how you will specifically adapt your approach to be sensitive to client diversity when developing the counseling relationship; this may include respecting cultured and gendered norms for emotional expression.]
   Relationship building intervention:
   a. **Join** with client using **social courtesy** and by respecting larger systemic culture and maintaining neutral position between clients and others.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* [Describe how you will assess broader cultural systemic dynamics and implications of individualist versus collectivist culture in assessment.]
   Assessment Strategies:
   a. Obtain detailed description of **problem behavioral sequences**.
   b. Identify **boundary**, **subsystems**, **triangles**, **hierarchy**, and **complementary patterns** that contribute to the problem.

Initial Phase Client Goals *(One to Two Goals): Manage crisis issues and/or reduce most distressing symptoms*

1. *Decrease* [name specific crisis behavior] to reduce [crisis] symptoms.
   Interventions:
   a. Directives to **interrupt crisis escalation** and enable alternative means to manage crisis.
   b. **Reframing** crisis situation to reduce sense of urgency and crisis.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* [Describe how you monitor the client's ongoing sense of connection with counselor and how you will specifically adapt monitoring and/or relationship based on client age, gender, cultural, sexual orientation, socioeconomic status, etc. If relevant, ensure positive alliance with clients and significant others not in session.]
   Assessment Intervention:
   a. Use Session Rating Scale; verbally ask client about alliance.

(*continued*)

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Working Phase Client Goals

1. *Increase* **interruptions to problem interaction cycle** to reduce depression/anxiety and so on.
   Interventions:
   a. **Directives** to do one small thing different to interrupt problem interaction pattern.
   b. **Systemic reframing** to alter response to problem pattern.
   c. **Paradoxical injunctions** to engage in symptomatic behavior in new context or with restraints.
2. *Increase* **clear boundaries**, **relational structure**, and **communication** to reduce depression and anxiety.
   Interventions:
   a. **Enactments** to clarify boundaries, triangles, and hierarchy.
   b. **Circular questions** to make problem dynamics overt.
3. *Increase* developmental, relational, and cultural appropriateness of **worldview** and **rules for relating** to reduce feelings of hopelessness, anxiety, fear, and so on.
   Interventions:
   a. **Circular questions** to increase awareness of relational assumptions.
   b. **Challenging worldviews** and **relational rules** that support and maintain the problem.

Closing Phase of Treatment

Closing Phase Counseling Tasks

1. *Develop aftercare plan and maintain gains. Diversity consideration:* Reassess functioning in all areas before ending counseling to ensure problem has not shifted to another aspect of system.
   Intervention:
   a. Reinforce new **epistemology and relational rules** and use **circular questions** to apply new skills to future challenges.

Closing Phase Client Goals

1. *Increase* **satisfying interactions** in intimate, social, and/or work relationships (whichever were not already addressed in working phase) to reduce feelings of hopelessness, anxiety, fear, and so on.
   Interventions:
   a. **Shaping competency** to transfer strengths from one area to another.
   b. **Circular questions** to capitalize on strengths and expand to new areas.
2. *Increase* **flexibility in worldview and relational interactions** to reduce potential for new problems to develop.
   Interventions:
   a. **Challenge rigid rules for relating and responding**.
   b. **Circular questions** to enable client to discover limits of worldview.

Snapshot: Bowen's Intergenerational Family Approach

Murray Bowen's (1976, 1985) intergenerational family approach combines a psychoanalytically grounded multigenerational approach with systems theory, resulting in a distinct and fascinating approach that traces relational patterns *across generations*. Bowen's theory posits that healthy adult functioning is characterized by *differentiation*, the ability to separate thought from feeling and self from others. Differentiation is critical because of

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the evolutionary process that has made humans *emotionally interdependent* due to an inherent *chronic anxiety* related to survival. Each family system develops patterns for managing closeness and distance and regulating anxiety; these patterns are passed down from one generation to the next. The more the family allows for differentiation between members, the less pathology its members experience. Intergenerational counselors are quick to distinguish between *emotional cutoff* and healthy differentiation. Emotional cutoff is a sign of low levels of differentiation that require a person to stop relating to a family member because of high levels of anxiety and fusion; in contrast, healthy differentiation is marked by high levels of emotional intimacy counterbalanced with autonomy. Another problematic means of managing chronic anxiety, *triangulation* (see the discussion of triangulation), refers to pulling in a third person to stabilize tension in a dyad, such as a mother who becomes close to a child to make up for intimacy she is not experiencing in the marriage.

The primary goals of intergenerational counseling are to (a) increase differentiation and (b) reduce emotional reactivity and chronic anxiety. Intergenerational counselors use *genograms*, a graphic representation of three or more generations that is similar to a family tree, to identify intergenerational patterns, such as emotional cutoff and triangulation. In addition, genograms can be used to identify other family patterns related to gender, death, personality, illness, mental health, substance abuse, sexual abuse, occupation, and so on. In session, intergenerational counselors relate to clients using a differentiated, *nonanxious presence* that role-models differentiation, reduces triangulation, and encourages clients' differentiation. The techniques of intergenerational counseling focus on encouraging client differentiation using process questions that help clients become more aware of intergenerational patterns.

Snapshot: Satir's Human Growth Model

One of the most influential women in the field of mental health, Virginia Satir (1972, 1983, 1988) developed a comprehensive family counseling model that integrated humanism and system theory. Her theory is based on four primary assumptions:

1. People tend naturally toward positive growth (humanistic principle).
2. All people possess the resources for positive growth (humanistic principle).
3. Every person and every thing or situation impact and are impacted by everyone and everything else (systemic principle).
4. Therapy is a process, which involves interaction between therapist and client; and, in this relationship, each person is responsible for himself/herself (systemic and humanistic principle). (Satir, Banmen, Gerber, & Gomori, 1991, pp. 14–15)

Similar to other experiential counselors (see Chapters 6–8), Satir used the person of the counselor to develop a warm, empathetic, and encouraging relationship with clients. In addition to using the systemic assessment ideas outlined above in this chapter, Satir also conceptualized family interactions in terms of the *communication* or *survival stances*. Survival stances refer to communication patterns a person adopts as a child to cope with difficult family interactions. She identified four different communication stances and one health stance:

- *Placating:* The person manages interpersonal stress by recognizing the needs of *others* and the *context* but not the *self*.
- *Blaming:* The inverse of placators, the person manages interpersonal stress by recognizing the needs of *self* and the *context* but not *others*.
- *Superreasonable:* The person manages interpersonal stress by recognizing *contextual rules* but not more subjective needs of *self* and *others*.
- *Irrelevant:* This person manages interpersonal stress by not acknowledging *contextual demands*, *personal needs*, or the *needs of others*.

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- *Congruent:* A person using a congruent stance is able to simultaneously honor the needs of self and respect the needs of others while responding appropriately to context.

The goals of Satir's approach are twofold: (a) to communicate congruently in all relationships and (b) to self-actualize (similar to other humanistic approaches). Satir uses an active style that includes having the family visually arrange each other to depict family dynamics using a technique called *family sculpting*. She also uses communication coaching to help clients learn how to communicate congruently. Another common intervention helps clients identify the *ingredients of an interaction*, helping them separate out (a) what is heard and said, (b) what meanings are made, (c) what feelings are felt about the meanings, (d) feelings about the feelings, (e) defenses that are used to manage feelings, (f) rules for communicating about the feelings, and, finally, (g) the outward response to the situation.

Research and the Evidence Base

Systemic therapy began as a research project: the Bateson team began by studying communication in families with members diagnosed with schizophrenia. The tradition of observational research has been integrated into required standard training in systemic and strategic models in the form of observation teams. Although there has been less systematic research on outcomes of specific systemic models, such as strategic, Milan, or MRI, there is consistent and growing research on the effectiveness of evidence-based systemic approaches for specific conditions, such as adolescent substance abuse, adolescent conduct issues, depression related to relationship distress, severe mental illness, and couple distress (Sprenkle, 2012). These evidence-based treatments use key theoretical concepts and techniques from systemic family therapies and apply them to a specific population.

Systemic therapies are quickly emerging as a leading force in the realm of evidence-based treatments. Numerous empirically supported treatments incorporate key elements of systemic and strategic therapies, including:

- **Brief Strategic Family Therapy** (structural ecosystemic therapy, structural ecodevelopmental preventive interventions)
- **Ecosystemic Structural Therapy** (Lindblad-Goldberg, Dore, & Stern, 1998)
- **Emotionally Focused Couples Therapy** (Johnson, 2004)
- **Functional Family Therapy** (Alexander, Waldron, Robbins, & Neeb, 2013; Sexton, 2010)
- **Multidimensional Family Therapy** (Liddle, Dakof, & Diamond, 1991)
- **Multisystemic Family Therapy** (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998)
- Although each of these approaches is unique, they all incorporate identifying the problem interaction sequence and in some way interrupting or altering it, using one or more systemic or strategic techniques, to address the needs of a specific population.

Evidence-Based Therapy: Emotionally Focused Therapy

In a Nutshell: The Least You Need to Know

Emotionally focused therapy (EFT) is one of the most thoroughly researched approaches in the field and is an empirically validated treatment for treating couples (Johnson, 2004). Sue Johnson and Les Greenberg (1985, 1994) developed the model using a combination of (a) attachment theory, (b) experiential theory (specifically, Carl Rogers's person-centered therapy), and (c) systems theory (specifically, systemic-structural

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therapies; Johnson, 2004). Emotionally focused therapists focus on the emotional system of the couple and use affect heightening to help couples restructure their interactional patterns to increase emotional intimacy and to address their attachment needs.

Attachment and Adult Love

Johnson (2004, pp. 25–32) uses Bowlby's theory of attachment to conceptualize adult love, identifying ten tenets of this theory:

1. *Attachment is an innate motivating force:* The desire to be connected to others is intrinsic.
2. *Secure dependence complements dependency:* Neither complete independence nor overdependence is possible, only effective or ineffective dependency.
3. *Attachment offers an essential safe haven:* Secure attachment provides a buffer for stress and uncertainty.
4. *Attachment offers a secure base:* A secure base allows for exploration, innovation, and openness.
5. *Emotional accessibility and responsiveness build bonds:* Secure attachment is established by being emotionally accessible and responsive.
6. *Fear and uncertainly activate attachment needs:* When threatened, a person experiences a strong emotional need for comfort and connection.
7. *The process of separation distress is predictable:* If attachment needs are not met, the person experiences predictable responses of anger, clinging, depression, and despair.
8. There are a finite number of insecure attachment styles:
   - *Anxious/hyperactivated:* When needs are not met, the person becomes anxiously clingy and relentlessly pursues connection and may become aggressive, blaming, and critical.
   - *Avoidance:* When needs are not met, the person suppresses attachment needs and instead focuses on tasks or other distractions.
   - *Combination anxious and avoidant:* In this style, the person pursues closeness and then avoids it once offered.
9. *Attachment involves working models of self and other:* People use the quality of attachments to define themselves and others as lovable, worthy, and competent.
10. *Isolation and loss are inherently traumatizing:* Isolation and loss of connection are inherently traumatic experiences.

EFT Tasks and Stages

Johnson (2004) identifies *three primary therapeutic tasks* of EFT:

Task 1: Creation and maintenance of alliance

Task 2: Assessing and formulating emotion

Task 3: Restructuring interactions

She also identifies *three stages with nine steps* that describe the progression of therapy (Johnson, 2004):

Stage 1: De-escalation of Negative Cycles

Step 1: Create an alliance and delineate conflict in the attachment struggle.

Step 2: Identify the negative interaction cycle.

Step 3: Access unacknowledged emotions and underlying interactional positions.

Step 4: Reframe problem in terms of negative cycle and attachment needs, with the cycle being the common enemy.

Stage 2: Change Interactional Patterns

Step 5: Promote identification of disowned attachment needs and aspects of self, integrating these into relational interactions.

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Step 6: Promote acceptance of the partner's experience along with new interaction sequences.

Step 7: Encourage expression of needs and wants while increasing emotional engagement and bonding to redefine the couple's attachment.

Stage 3: Consolidation and Integration
Step 8: Facilitate new solutions to old problems.

Step 9: Consolidate new positions and new cycles of attachment.

Tapestry Weaving: Diversity Considerations

Ethnic, Racial, and Cultural Diversity

Because systemic and strategic family therapies do not rely on a theory-based definition of health and normalcy, they adapt relatively easily to different cultural groups and subpopulations: "Since in strategic family therapy a specific therapeutic plan is designed for each problem, there are no contraindications in terms of patient selection and suitability" (Madanes, 1991, p. 396). Furthermore, drawing on systemic and constructivist foundations, these therapies aim to work from *within* the client's worldview; when this is successfully achieved, the counselor adapts the language and interventions to the client's values and beliefs.

Hispanic and Latino Clients

Of particular interest, two groups of systemic counselors have systematically adapted and used the approach with Latino/Hispanic clients. The Latino Brief Therapy Center at the MRI uses the nonnormative and nonpathologizing principles of the model to guide their work, creating unique meaning and interventions with each client, rather than rely on cultural stereotypes of the extremely diverse Latino community (Anger-Díaz, Schlanger, Rincon, & Mendoza, 2004). Similarly, Brief Strategic Family Therapy, an evidence-based approach that uses elements of systemic and structural family therapies, was developed specifically to treat Hispanic youth with high-risk behaviors and substance issues; the approach has also been found to be effective with African American youth (Robbins, Horigian, Szapocznik, & Ucha, 2010; Santisteban, Coatsworth, Perez-Vidal, Mitrani, Jean-Gilles, & Szapocznik, 1997).

In addition to these specific treatment approaches, McGoldrick, Giordano, and Garcia-Preto (2005) provide descriptions of how systemic ideas and approaches can be modified to meet the needs of families from 46 different ethnicities, an invaluable resource when working with cultural groups other than one's own (and perhaps your own; read and see). Although these descriptions must be general and do not capture the unique lived experience of a particular client that may be in front of you at a given moment, they can give you, the counselor, a clue about how best to understand and engage the client (and most clients appreciate your having at least a clue about their background and giving them room to share their own unique experience and beliefs).

Asian Indian Immigrants

Rastogi (2007) describes how systemic family counseling can be used with Asian Indian immigrant families, the majority of whom have immigrated to the states in the past five decades. She identifies several specific cultural issues to consider when working from a systemic perspective:

- *Intergenerational family structure:* Asian Indian families are multigenerational families. Even after one generation immigrates, the family is likely to stay closely connected, both emotionally and physically, with many choosing three-generation households. Asian Indians often present in counseling with intergenerational conflict, which is often exacerbated by immigration. When working with Asian Indian families, Rastogi (2007) encourages counselors to carefully consider family

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boundaries and role expectations from within the cultural norms. Furthermore, using a genogram to identify intergenerational patterns can also be helpful to Asian Indian families because it enables them to make sense of each other's perspectives and identify culturally consistent possibilities for resolving concerns.

- *Collectivist value system:* Asian Indians are socialized to value family and contribute to the broader community, which also serves as a significant source of support and identity. Thus, systemic concepts such as "individual differentiation" should be used cautiously with these clients, recognizing that obligations to the community often take precedence over individual desires and that intergenerational conflict regarding these values is common.
- *Respect-based hierarchy:* Many Asian Indian families adhere to a traditional intergenerational hierarchy within the family based on age and gender. The older generations are respected, and their advice is sought by younger generations when making important life decisions. Counselors should respect this hierarchy and potentially use it to bring out the best in the elders, who are expected to be compassionate and wise leaders, as well as to help younger generations identify meaningful ways for them to continue this tradition.
- *Impact of modernization on Asian Indian families:* For many Asian Indian families, the effects of modernization, such as geographical mobility and egalitarian beliefs, have lead to relationship crises intergenerationally. Many elders find themselves isolated and without the familial role and purpose they expected in later life, which often leads to conflict with younger generations when they embrace American values of independence. Counselors can help these clients by finding ways to honor their traditional culture while making room for the realities and demands of modern life.
- *Action Before Words:* Rastogi (2007) also notes that many Asian Indians communicate their affections and regrets through their actions rather than words. For example, after a fight, it would be more typical to reconcile by enacting the desired action that was the topic of conflict, rather than to say, "I'm sorry. I won't do that again." Thus, rather than encourage clients to reconcile with words (the "natural" preference of professional counselors and contemporary American culture), counselors can help clients identify appropriate actions that would communicate the message they want to send.

Sexual Identity Diversity

Because of its nonpathologizing and nonnormative assumptions and its attention to larger systemic dynamics, systemic therapies have been widely used with clients who identify as lesbian, gay, bisexual, transgendered, or questioning (LGBTQ). Butler (2009) identifies five principles for adapting systemic therapy approaches for these clients.

1. *Understanding heterosexism:* Counselors need to be aware that gender and sexual minorities have *daily* experiences of being marginalized, judged, and ignored, and rarely see their reality reflected in advertisements, movies, and other social forums.
2. *Counselor self-reflectivity:* Heterosexual counselors need to engage in personal self-reflection of their experience of being privileged and having their sexual and gender orientations generally approved by society.
3. *Locating your position, transparency, and self-disclosure:* Based on the work of feminist counselors, Butler recommends disclosing one's gender and sexual orientation when working with LGBTQ clients. Such openness allows for frank discussions about areas of similarity and differentness, helping to address issue of power and hierarchy. However, too much self-disclosure can be nonproductive.
4. *Client as expert, and counselor as curious:* Drawing upon collaborative therapy principles (see Chapter 13), counselors should assume a curious stance, viewing the client as the expert in their lives and lifestyle.
5. *Connecting to wider systems:* Finally, counselors should consider the larger social systems of which their LGBTQ clients are a part and encourage them to seek positive, supportive communities.

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Butler (2009) also discusses how counselors need to adjust their approach with LGBTQ couples. First, counselors should be aware that sex, gender roles, monogamy, family of origin, family of choice, and ex-partners generally have very different meanings with these couples. Furthermore, gender roles are thought to have more impact than sexual orientation per se in these relationships, with internalized gender roles often greatly restricting same-sex relationships and being a particular issue in couples with a transgendered partner. Counselors can help couples to deconstruct their gender role expectations and assumptions in ways that strengthen the partnership. Finally, counselors should keep in mind that the family life cycle looks different for most LGBTQ individuals, couples, and families (Goldberg, 2009).

Adolescents Coming Out to Family

Another common issue that counselors address is adolescents coming out to their families (Butler, 2009). First and foremost, counselors should be aware that gay, lesbian, bisexual and transgendered youth have higher rates of suicidality, substance abuse, self-harm, depression, anxiety, and school issues; so it is important to monitor the adolescent's safety and well-being. Before coming out, most adolescents are generally able to accurately predict their parents' responses based on casual comments about sexuality over the years. Counselors can use DeVine's (1984) stage theory for the family's process of coming out to help families negotiate this transition.

- *Subliminal awareness:* The child's sexuality is suspected and sometimes provoked by inquiries about dating and same-sex friendships.
- *Impact:* The child announces his/her sexuality and suspicions are confirmed.
- *Adjustment:* The family struggles to maintain its old homeostasis while the child is expected to hide or deny his/her sexuality.
- *Resolution:* The family comes to accept the child's sexuality identity.
- *Integration:* The family shifts their values related to gender and sexual norms.

Many parents whose child comes out report a "loss" of their dreams of having a wedding or grandchildren, and much of their initial response may actually reflect the personal losses they are projecting. Counselors can help redirect parents to focus on their child's real needs at this time, while also developing a more hopeful view of their future family life.

Transgendered Youth

There is little research or literature to guide counselors when working with transgendered persons, especially youth. However, unlike gay, lesbian, and bisexual youth, transgendered youth often cannot hide their difference, and thus it is more likely to be a point of family discussion whether the child wants it public or not (Coolhart, Baker, Farmer, Malaney, & Shipman, 2012). The majority of transgendered youth (59%) report negative parental reactions to their gender identity, at least initially, with those more gender nonconforming reporting greater conflict with parents (Grossman, D'Augelli, Howell, & Hubbard, 2005). However, parental acceptance is important for transgendered individuals, correlated with adult life satisfaction and self-esteem (Erich, Tittsworth, Dykes, & Cabuses, 2008).

Coolhart and colleagues (2012) outline an assessment tool for counselors working with transgendered youth and their family. They recommend working with the family of transgendered youth whenever possible, attending to systemic dynamics. The assessment tool is comprised of questions that cover nine domains:

- *Early awareness and family context:* These questions address the general family structure and history as well as as both parents' and youth's early gender experiences. For example: "Please provide additional information about how your family's context in terms of racial, ethnic, and national communities interfaces with beliefs about variant expressions of gender and sexuality" (Coolhart et al., 2012, p. 16).
- *Parents' Attunement with Youth's Affirmed Gender:* These questions address how the parents and family have responded to the youth's transgender identity.

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For example: "When your child disclosed (or you discovered) their transgender identity, what was this experience like for you individually, as a couple, and as a family as a whole?" (Coolhart, 2012, p. 17).

- *Current Gender Expression:* These questions address the youth's current preference for expressing gender. For example: "Have you dressed privately in clothing typically associated with your affirmed gender? When did you first begin to dress in private? How did it feel when you first began to dress in private? Did anyone else know? If so, what was their reaction?" (Coolhart, 2012, p. 17).
- *School Context:* These questions explore the youth's experience and possible harassment at school related to gender identity. For example: "What is your current gender expression at school? Are you 'out' to any of your friends?" (Coolhart, 2012, p. 18).
- *Sexual Relationships/Development:* These questions are typically asked of the youth in private and address sexual orientation, abuse, and activity: "How do you identify your sexual orientation? Have you ever experienced or witnessed sexual or physical abuse?" (Coolhart, 2012, p. 19).
- *Current Intimate Relationship(s):* If the youth is involved in a current relationship, the counselors inquires about the relationship and the partner's knowledge of the youth's gender identity and possible interest in transitioning.
- *Physical and Mental Health:* These questions assess for physical and mental health issues that may need addressing, including the potential for self-harm and substance abuse.
- *Support:* The questions aim to identify sources of support for the family and youth, including family, friends, church, neighbors, support groups, Internet connections, and such.
- *Future plans/Expectations:* This last set of questions explores whether the youth has plans for gender transition, hormone therapy, surgery, children, and so on.

Systemic Case Study

Navid, a 22-year-old of Persian descent, has come to counseling because his parents have insisted he deal with his pot use, or they will not pay for him to finish his last semester at an elite private college. Navid admits that his grades have plummeted this last semester, but he claims that it is because his parents want him to become a doctor, and he does not want to. He says that he smokes pot only on the weekends with friends and when he is stressed and preparing for an exam; he denies other substance use except for drinking "a few beers" at parties. He prefers to play music—he is an avid guitarist—but his parents say that is not a real profession. His younger sister in high school, who is the "perfect one," understands his frustration but would never speak up for him in a conversation with their parents. His parents recently caught him smoking pot during a recent visit home. His uncle, a medical doctor, was called in to "educate" him about drugs. His father stopped talking to him for the rest of the visit because he was so upset by Navid's choice to "throw his life away after all I've done for him." He reports hearing his mother frequently cry over the incident. Navid said he really doesn't care about graduating but is coming to counseling because he doesn't know what else to do with his family and his life.

Case Conceptualization: Systemic

This case conceptualization was developed by selecting key concepts from the "The Viewing: Case Conceptualization" section of this chapter. You can use any of the concepts in that section to develop a case conceptualization for this or other cases.

Strengths

Some of AM's strengths include his intelligence, musical ability, awareness of family dynamics, and a willingness to come to counseling. The family's strengths include

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valuing and supporting AM's professional success, involvement of extended family, and caring for each other and the welfare of the family.

Family Life Cycle Stage of Development

The family is in the early phases of launching, which requires some of the most significant changes in the family life cycle and affects all parties and relationships, including the marriage, which is in the process of becoming the parent's primary relationship again. The parents are still using more traditional Iranian authoritarian parenting methods rather than an authoritative or even mentoring style to encourage AM to learn to make good decisions without their intervention, which is more typical in the United States in the launching stage.

Furthermore, although it is tempting to see AM's behavior as a type of rebellion against his family, systemic analysis reveals a different dynamic. At a systemic level, it serves to keep the parents in a parenting position and also keep AM in the child role by engaging in behaviors that—by the family's cultural and socioeconomic standards—require parental intervention, even if he is 22. Thus, his substance use serves to keep the family connected and roles stable during the difficult period of launching.

Boundaries

In general, the boundaries in the family have followed traditional Iranian values, which includes closeness and loyalty to the family. AM's father has typically had more rigid boundaries with the children, using more authoritarian parenting approaches. The mother is more emotionally connected with the children but never counters what the husband says or does, as that would be disrespectful. AM reports being closest to and having the clearest boundaries with his sister. His extended family is also very involved—often overly involved and enmeshed—in the family affairs.

Triangles/Coalitions

AM and his sister have a strong sibling subsystem in which they understand each others' desire to adopt more Western values, such as doing what you love rather than what will best support the family, and it is therefore a subsystem organized around immigration and acculturation values. Additionally, extended family members, namely, the uncle, also are part of the parenting subsystem, as is culturally common in immigrant families.

Hierarchy

As is common in Iranian families, there is a clear hierarchical structure with the father at the head of the household. Although this hierarchical arrangement is within norms for traditional Iranian culture, it would be considered rigid by American standards; thus, AM, who has adopted more American values, is rebelling against this more traditional hierarchy. This conflict is not uncommon in immigrant families.

Complementarity

In this family, the father tends to play the "bad parent" and the mother the "good/nice parent," as evidenced by their reaction to the substance use. AM and his sister are playing complementary roles right now as good/bad child.

Intergenerational Patterns

- *Family strengths:* Family is loyal to one another and available to each other during crisis; the family has significant financial means.
- *Substance/alcohol abuse:* None reported except for AM's current situation.
- *Sexual/physical/emotional abuse:* None reported.
- *Parent/child relations:* Historically, the family has had traditional parent-child hierarchy, in which children respected the wishes of parents and the parents sacrificed to provide their children with a better life than they had.
- *Physical/mental disorders:* Family has a history of depression on the mother's side.
- *Historical incidents of presenting problem:* None.

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Treatment Plan: Systemic

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration:* Assess for AM's level of acculturation and adapt style of connection and emotional expression to Persian norms.
   Relationship building intervention:
   a. **Join** with AM using **social courtesy** and by respecting family's culture and class; maintain a neutral position when AM discusses frustration with his family, especially the father.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Consider Persian norms and assess level of acculturation and education before assessing family dynamics.
   Assessment Strategies:
   a. Obtain detailed description of **problem behavioral sequences**, encouraging nonblaming descriptions of each person's actions.
   b. Identify **boundary**, **subsystems**, **triangles**, **hierarchy**, and **complementary patterns** that contribute to AM's substance use and family conflict.

Initial Phase Client Goals

1. *Increase* AM sense of concern about his future to increase responsible decision making and reduce use of marijuana.
   Interventions:
   a. **Reframing** crisis situation to increase AM's sense of personal responsibility for life direction and reduce need to rebel against father.
   b. Directives to **interrupt escalation of substance use when stressed** and identify alternative means to manage stress.

Working Phase of Treatment

Working Phase Counseling Tasks

1. *Monitor quality of the working alliance. Diversity consideration:* Ensure positive alliance with AM and family members who are not in session; adapt communication considering Persian norms and education level.
   Assessment Intervention:
   a. Use Session Rating Scale; verbally ask AM about alliance.

Working Phase Client Goals

1. *Increase* AM's ability to **interrupt problem interaction cycle** and do something different to reduce stress related to father and motivation to use substances.
   Interventions:
   a. **Directive** to do one small thing different on his part to interrupt problem interaction pattern, such as writing a thank-you to uncle.
   b. **Systemic reframing** that frames his substance use as a way his father is *still* controlling him because he is simply being the antithesis of what father wants rather than own person.
   c. **Ordeal and paradoxical directions** that require AM to engage in unappealing ordeal before substance use in order to reduce use.

(*continued*)

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2. *Increase* **clear boundaries with parents** that allow for better communication of personal needs and wishes to reduce self-sabotaging substance use.
   Interventions:
   a. **Enactments** adapted for individual to help AM practice alternative ways of responding to parents.
   b. **Circular questions** to increase AM's understanding of the covert family dynamics and his role in perpetuating them.
3. *Increase* developmental and cultural appropriateness of AM's **rules for relating** to reduce his use of substances and increase responsibility for life direction.
   Interventions:
   a. **Circular questions** to increase awareness of relational assumptions that underlie family conflict and AM's substance use.
   b. **Challenging worldviews and relational rules** that support and maintain the problem while remaining respectful of cultural norms.

Closing Phase of Treatment

Closing Phase Counseling Tasks

1. *Develop aftercare plan and maintain gains. Diversity consideration:* Consider Persian and university community resources.
   Intervention:
   a. Reinforce new **epistemology and relational rules** and use **circular questions** to apply new skills to future challenges.
   b. Reassess functioning in all areas before ending counseling to ensure problem has not shifted to another aspect of system.

Closing Phase Client Goals

1. *Increase* **satisfying interactions** with nuclear and extended to reduce feelings of hopelessness.
   Interventions:
   a. **Shaping competency** to transfer strengths from relating to father to relating to all family members.
   b. **Circular questions** to capitalize on strengths and expand to new areas.
2. *Increase* effective **development transition** to young adult who makes good life decisions without parents' intervention to reduce substance abuse and self-sabotage.
   Interventions:
   a. **Challenge rigid definitions of self** based on old role in system as child.
   b. **Circular questions** to increase AM's ability to see the responsibilities and possibilities of his new development stage more clearly.

Questions for Personal Reflection and Class Discussion

1. Identify a personal characteristic of yours that has a strong systemic component (i.e., you are this way more in one relationship than in another or it has been exaggerated over the years due to complementarity with a partner).
   - Does this characteristic feel like it is an inherent characteristic of "you" or does it feel "situational"?
   - Can you identify a characteristic of another person that seems "inherently in the individual" but may have more of a systemic basis to it?
   - Would you agree that to some extent all behavior is shaped by broader systemic and social dynamics? Why or why not?

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2. What would "joining the system" look like in your family of origin?
3. Are you ready to "trust the system" to reorganize itself in a way that is best for itself? Why or why not?
4. Where are you currently in the family life cycle? How are you approaching the tasks of balancing independence and interdependence?
5. Trace a problem interaction cycle in your life from "normal" through the rise in tension and symptom and back to "normal" again.
6. How do cultural communities function as a system in a person's life?
7. How do culture and gender play out in your family system?
8. How might the experience of being marginalized due to same-sex orientation affect a person's boundaries with:
    - a partner?
    - a supportive family of origin?
    - a nonsupportive family of origin?
    - supportive friends?

Online Resources

Associations and Institutes

American Association of Brief and Strategic Therapists
www.aabst.org

American Association for Marriage and Family Therapy
www.aamft.org

Brief Strategic and Systemic World Network
www.bsst.org

Brief Strategic Family Therapy Training
www.brief-strategic-family-therapy.com

BSFT Training Manual
www.nida.nih.gov/TXManuals/bsft

International Association of Marriage and Family Counselors
www.iamfconline.com

Functional Family Therapy
www.fftinc.com

Mental Research Institute
www.mri.org

Multisystemic Therapy
www.mstservices.com

Philadelphia Child and Family Therapy Training Center
www.philafamily.com

Journals

Family Process
www.familyprocess.org

Journal of Marital and Family Therapy
www.jmft.net

Journal of Systemic Therapies
www.guilford.com

Videos

See the Theory in Action Videos at Cengagebrain.com

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*Asterisk indicates recommended introductory readings.

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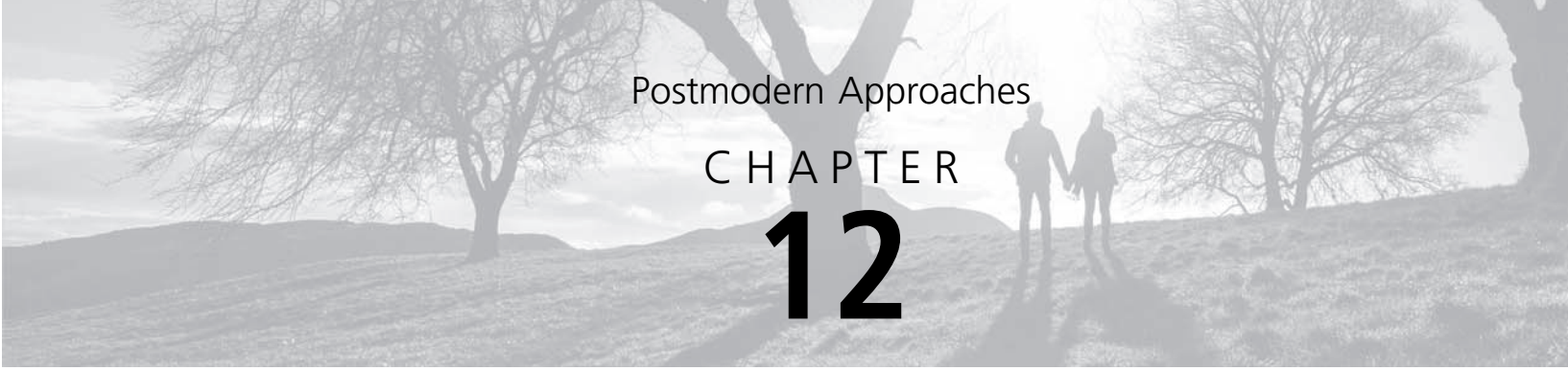

Postmodern Approaches

CHAPTER

12

Solution-Based Approaches

One of the most important aspects of SFBT [solution-focused brief therapy] is the general tenor and stance that is taken by the therapist. The overall attitude is positive, respectful, and hopeful. There is a general assumption that people have within them strong resiliencies, and can utilize these to make changes. Further, there is a core belief that most people have the strength, wisdom, and experiences to effect change.

—de Shazer et al. (2007, p. 4)

Lay of the Land

If you have been waiting for an upbeat and eminently practical theory in this book, you may enjoy meeting this optimist group of counselors. The quintessential strength-based approach, solution-based counseling is a positive, future-focused, and active approach that helps clients take small, consistent steps toward enacting their solutions. Broadly speaking, there are three strands of practice, which share more similarities than differences:

- *Solution-focused brief therapy (SFBT)*, developed by Steve de Shazer (1985, 1988, 1994) and Insoo Berg at the Milwaukee Brief Family Therapy Center, emphasizes a future focus with minimal discussion of the presenting problem or the past; interventions target small steps in the direction of the solution.
- *Solution-oriented therapy* (O'Hanlon & Weiner-Davis, 1989) and the related approach *possibility therapy* (O'Hanlon & Beadle, 1999), developed by Bill O'Hanlon and colleagues, share many tenets and practices with SFBT, adding more language-based techniques and more interventions that draw from the past and present to identify potential solutions.
- *Solution-focused school counseling* has been widely used in school contexts because of its brief and strengths-based characteristics (Cooley, 2009; Davis & Osborn, 2000; Kelly, Kim, & Franklin, 2008; Metcalf, 2003, 2007; Murphy, 2008; Parsons, 2009; Sklare, 2004). Solution-focused school counselors work with individual students, teachers, staff, and administrators to improve individual student and entire classroom performance and behavior.

Because of the numerous commonalities, I will present brief solution-focused and solution-oriented approaches together in this chapter; special applications for school counseling are presented in a separate section at the end.

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Solution-Based Counseling

In a Nutshell: The Least You Need to Know

Solution-based counseling evolved from systemic family counseling (see Chapter 11) and the work of the Mental Research Institute (MRI) as well as Milton Erickson's brief therapy and trance work (de Shazer, 1985, 1988, 1994; O'Hanlon & Weiner-Davis, 1989). Both Steve de Shazer and his wife Insoo Kim Berg collaborated with the colleagues at MRI, who conceptualized interventions around problem formation and problem resolution. In contrast, de Shazer and Berg based their work on solutions, boldly proclaiming that the *solution is not necessarily related to the problem* (de Shazer, 1988). They developed their work around the miracle question, which invites clients to describe what they would notice happening differently (not what would *not* be happening) if the problem were miraculously solved overnight without their knowledge. This concrete, behavioral description of the solution is then used to develop interventions to help clients take small, consistent steps toward change. In addition to the miracle questions, solution-based counselors use exception questions to identify times without the problems, and scaling questions to break the solution down into small, easily achievable steps. Rather than being "solution givers," solution-based counselors collaborate with the client to envision potential solutions based on the client's experience and values. If ever the process seems to get stuck, the counselor does not blame the client's lack of effort but instead works with the client to identify more appropriate and viable routes to change. As this approach is goal-focused and emphasizes measurable change, it tends to be brief, making it a favorite approach in managed care environments, schools, and other time-limited contexts.

Common Solution-Based Therapy Myths

More so than others, solution-based counselors are haunted by myths and misconceptions about what actually happens in session. So let's straighten these out before we go any further.

Myth: Solution-based counselors propose solutions to clients (which amounts to advice giving).

Closer to the truth: Solution-based counselors do not suggest logical solutions to clients (O'Hanlon & Beadle, 1999). Instead, it is primarily the job of the client to identify solutions with the help of the counselor, who identifies *exceptions* to the problem, descriptions of what is already working, and client resources to help the client envision potential solutions. Once a clear, behavioral goal is identified, the counselor works with the client to take small steps in this direction.

Myth: Solution-based counselors *never* talk about the problem.

Closer to the truth: Solution-based counselors are not psychic and therefore, like all counselors, must spend some time talking about the problem. However, they spend *less* time talking about the problem than most other counselors, especially SFBT counselors (De Jong & Berg, 2002). Solution-based counselors typically follow the lead of clients in determining how much and how often they need to talk about the problem versus the solution. To add further myth-busting evidence, hallmark techniques, such as *exception questions*, require talking about the problem as part of identifying the solution.

Myth: Solution-based counselors *never* talk about the past.

Closer to the truth: Again, solution-based counselors are not psychic and actually have numerous techniques that are grounded in talking about the past. However, when they talk about the past, they focus on the strengths as well as the problem (Bertolino & O'Hanlon, 2002). Talking about the past is one of the most important means of identifying exceptions, strengths, and solutions. The past is talked about in ways that facilitate the enactment of solutions.

Myth: Emotions are not discussed in solution-based counseling.

Closer to the truth: Emotions cannot be avoided in therapy, even by solution-based counselors. However, solution-based counselors do not view emotions as inherently within an individual or consider the expression of emotions curative, as is often assumed in psychodynamic

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and humanistic approaches (Lipchick, 2002). Instead, emotions are viewed as intimately connected with context, having idiosyncratic meaning, and are used as clues as to what works and where clients want to go.

The Juice: Significant Contributions to the Field

If you remember one thing from this chapter, it should be …

Scaling Questions and the Miracle Scale

If I were challenged to use only one technique to work with clients from start to finish, scaling questions would have to top the list of possibilities, because they are arguably one of the most versatile and comprehensive interventions. Counselors can use scaling questions to (a) assess strengths and solutions, (b) set goals, (c) design homework tasks, (d) measure progress, and (e) manage crises with safety plans (see "Scaling for Safety" in Gehart, 2010). They can be used in the first session and can be reused weekly until the last. Like many modern-day miracle, all-in-one products—such as shampoo-conditioners, moisturizer-sunscreen-foundations, and car wash-and-waxes—this technique is likely to be one of your go-to techniques for years to come.

As the name indicates, *scaling questions* involve asking clients to define their goals and rate their progress toward them using a scale, most often a ten-point scale, but sometimes percentages or shorter, nonnumeric versions are used with children (Bertolino, 2010; de Shazer, 1994; O'Hanlon & Weiner-Davis, 1989; Selekman, 1997). De Shazer et al. (2007) recommend having 0 represent "when you decided to seek help" rather than when things are "at their worst." When scaling 0 to mean "at their worst," this can refer to decades earlier or have different meanings to different people. Instead, scaling from "when you decided to seek help" allows for a clearer system for measuring progress from the beginning to end of counseling; they refer to these as "miracle scales" and use these scales to follow up with the miracle question (see "The Viewing: Case Conceptualization" section). Others use 0 or 1 to represent things at their *worst* (Bertolino, 2010).

Two Approaches to Scaling

Miracle Scale: Measures Progress From Beginning of Counseling

When You Decided to Seek Help — *Miracle Situation*

0---------1--------- 2--------- 3--------- 4--------- 5--------- 6--------- 7--------- 8--------- 9--------- 10

Worst-to-Solution Scale: Measures Progress in General

Things at Their Worst — *Solution*

0---------1--------- 2--------- 3--------- 4--------- 5--------- 6--------- 7--------- 8--------- 9--------- 10

Scaling questions can be used early in the counseling process to help identify meaningful long-term goals, much the way the miracle question is used (see the following box):

Scaling Question for Long-Term Goal Setting (assessing solutions and setting goals)

If you were to put your situation on a scale from 1 to 10 with 0 being where you were when you decided to seek help (or at their worst) and 10 being where you'd like to be, can you describe to me what you would be doing *(not* what you would *not* be doing) if things were at a 10? Where are you today? What was happening, and what were you doing at a 0?

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As the client responds, the counselor listens for clear, specific descriptions of what life would be like at a 10, helping the client to paint a clear, behavioral picture: what is the client doing, what are others doing, and how does the day go? Once a clear description of the 10 scenario is developed, the counselor can then ask where things are today and obtain a behavioral description of the current situation. A concrete description of when things were at the point the client decided to seek help or at their worst (0 or 1) can also be useful assessment information. Once the big picture is assessed, the same scale can be used to identify *what works*.

Scaling Question for Assessing What Works

If 0 is where you were when you decided to seek help and 10 is where you would be if the problem you came here for was resolved, where are you today? [If above a 0] What are you doing or what is happening that tells us you are at a 3 and not 0? How did you get from a 0 to here?

This next set of questions helps identify what works, exceptions, and potential solutions that need to be assessed before more specific interventions can be developed. If the client gets stuck answering any of these questions, it can be helpful to ask what significant others might rate them on the scale. After exploring where a client is this week, where he or she was when deciding to seek counseling, and where he or she would like to be, it is time to use scaling to identify the next step.

Scaling Question for Designing Week-to-Week Interventions and Tasks

On a scale from 0 to 10 with 10 being your desired goal, where are you this week? [Client responds and rates: e.g., 3]. If you are at a 3 this week, what things would need to be different in your life for you to come in and say you were at a 4, one step higher (or *half* a step higher if client tends toward pessimism or needs to keep goal smaller)?

This is not an easy question to answer. Often clients rush ahead and describe an 8, 9, or 10 when the next step is really a 4. In such cases, the counselor needs to help clients identify more realistic expectations. In other cases, clients say, "I don't know"; when this happens, counselors need to practice patience, silence, and encouragement to help clients identify ministeps toward their goal, which is a critical part of the process. The client—not the counselor—is the only person who can answer this question in any meaningful way. Remember, the counselor is *not* a solution giver.

Once a clear description of the next step is developed, this information is used to identify specific, small tasks the client can do during the next week to move one step higher on the scale. It generally takes an entire session to fully flesh out concrete steps that are (a) realistic and meaningful and (b) something that the client is motivated to try. For the intervention to work, the counselor and client need to develop microsteps that take into account the client's motivation, willingness, schedule, variations in the schedule, reactions of others, and so on. The counselor asks questions to identify, and listens for, potential barriers and pitfalls as well as helpful resources, working with the client to find ways to negotiate these. Together, the clients and counselors work to develop specific homework tasks that clients believe will help move them toward their goals.

For example, if the client's initial response is that "At a 4, I would feel less anxious," the counselor needs to ask follow-up questions, such as "How would you know you were less anxious?" "What would you be doing differently?" "How would your days be different?" "What changes would other people notice in you?" These questions help the client identify one or two specific, small steps to be taken over the week, such as "invite a friend over," "go to the mall alone," "watch a funny movie," and so on. The steps need to be small enough that the client thinks the steps are easily attainable, especially early in the process.

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Scaling Question for Measuring Progress

Last week you said you were at a 3. Where would you say you are this week and why? [If things got better] What did *you do* that helped move you up the scale? [If things stayed the same or got worse] What happened that kept things the same (or made them worse)?

The counselor follows up the next week to see if the homework tasks helped move clients closer to their goals. If so, they explore what helped and how to do more of it. If clients don't report progress or report that things got worse (with or without doing the homework), the counselor does not despair but simply goes back to more carefully assess whether (a) the solution has been meaningfully assessed and concretely identified and (b) whether the task was small enough, concrete enough, and motivating enough. This scale can be used to measure progress from the beginning to the end of the counseling process. In the case study at the end of this chapter, scaling questions are used throughout treatment to help Marcella cope with the death of the brother who abused her and with resurfacing memories of the abuse; in the early stages, scaling questions are used to help manage cutting (Selekman, 2006) and in the later phases to help her take action to resolve issues related to the abuse.

Rumor Has It: The People and Their Stories

Behind-the-Scenes Inspiration

Milton Erickson A physician and psychiatrist, Milton Erickson was a master clinician, well known for his brief, rapid, and creative interventions, and whose work greatly influenced the solution-based work of Steve de Shazer and Bill O'Hanlon (Erickson & Keeney, 2006; Haley, 1993; O'Hanlon & Martin, 1992). Erickson did not follow a specific theory but instead relied on keen observation while listening with an open mind to each patient's unique story. Erickson frequently employed *light trance* to evoke patient strengths and latent abilities (Haley, 1993; O'Hanlon & Martin, 1992). At a time when most forms of psychotherapy focused on the past, Erickson directed his clients to focus on the present and future, often *envisioning future times without the problem*, a frequent goal of solution-based techniques. Although others have meticulously studied his work, there has been no consensus or singular definition of Ericksonian therapy. The influence of his trance work is clearly evident in intervention such as the *miracle question* and *crystal ball technique*, which rely on a *pseudo-orientation to time* as well as the *implicit assumption* that change *will* occur.

Solution-Focused Brief Therapy: Milwaukee Brief Family Therapy Center

Steve de Shazer Steve de Shazer was a theorist, clinician, philosopher, and prolific writer (de Shazer, 1985, 1988, 1994; de Shazer et al., 2007), laying much of the philosophical and theoretical foundations for the solution-focused approach. After his early work at MRI with Jay Haley, Paul Watzlawick, John Weakland, and Virginia Satir, the late Steve de Shazer developed with his wife Insoo Kim Berg solution-focused brief therapy. His early work was influenced by the trance work of Milton Erickson (de Shazer, 1985, 1988) and his later work by Ludwig Wittegenstein's philosophy of language, who viewed language as inextricably woven into the fabric of life (de Shazer et al., 2007). With Insoo Kim Berg, he founded the Milwaukee Brief Family Therapy Center and the Solution-Focused Brief Therapy Association, where they taught until their deaths in 2005 (Steve) and 2007 (Insoo). He is remembered thusly: "An iconoclast and creative genius known for his minimalist philosophy and view of the process of change as an inevitable and dynamic part of everyday life, he was known for reversing the traditional psychotherapy interview process by asking clients to describe a detailed resolution of the problem that brought them into therapy, shifting the focus of treatment from problems to solutions" (Trepper, Dolan, McCollum, & Nelson, 2006, p. 133).

Insoo Kim Berg Warm and exuberant, the late Insoo Kim Berg was an energetic developer and leading practitioner of SFBT, cofounding the Milwaukee Brief Family Therapy

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Center and the Solution-Focused Therapy Association with her husband, Steve de Shazer (Dolan, 2007). She was an outstanding clinician who furthered the development of SFBT, developing solution-focused approaches to working with drinking issues (Berg & Miller, 1992), substance abuse (Berg & Reuss, 2007), family-based services (Berg, 1994), child protective services (Berg & Kelly, 2000), children (Berg & Steiner, 2003), and personal coaching (Berg & Szabo, 2005).

Scott Miller, Barry Duncan, and Mark Hubble Originally trained in a brief solution-focused therapy approach, Scott Miller, Barry Duncan, and Mark Hubble have been strong proponents of the *common factors* movement (see Chapter 1; Miller, Duncan, & Hubble, 1997) and client-centered, outcome-informed therapy. Their recent works emphasize using client feedback to improve outcomes and activate common factors in everyday practice.

Yvonne Dolan Yvonne Dolan studied and worked with de Shazer and Berg at the Milwaukee Brief Family Therapy Center, specializing in sexual abuse and trauma treatment (Dolan, 1991, 2000). Her work represents one of the first hopeful strength-based approaches to working with sexual abuse.

Solution-Oriented Therapy

Bill O'Hanlon A former student of Milton Erickson, Bill O'Hanlon is an energetic and popular leader in solution-oriented, strength-based counseling, including solution-oriented therapy and possibility therapy (O'Hanlon & Beadle, 1999; O'Hanlon & Weiner-Davis, 1989). A prolific and highly accessible writer and speaker, O'Hanlon's solution-oriented approach emphasizes the significance of language, using subtle shifts in language to spark change. His work aims to transform client *viewing* as well as *doing* of the problem while attending to broader *contextual* issues that impact the client's situation (Bertolino & O'Hanlon, 2002). He has written extensively on numerous topics, including solution-oriented couples therapy (Hudson & O'Hanlon, 1991), solution-oriented approaches to treating sexual abuse (O'Hanlon & Bertolino, 2002), solution-oriented hypnosis (O'Hanlon & Martin, 1992), solution-oriented therapy with children and teens (Bertolino & O'Hanlon, 1998), and spirituality in therapy (O'Hanlon, 2006), as well as books for clients and popular audiences (O'Hanlon, 2000, 2005, 2006).

Michelle Weiner-Davis Michelle Weiner-Davis developed a highly successful solution-oriented approach to working with divorce that she calls *divorce busting* (Weiner-Davis, 1992). She uses a brief, solution-oriented self-help approach to help couples wanting to prevent divorce.

Solution-Focused Approaches in Schools

Michael Kelly, Johnny Kim, and Cynthia Franklin Michael Kelly, Johnny Kim, and Cynthia Franklin (Kelly et al., 2008) use solution-focused brief therapy in school contexts and have developed a classroom consulting method, "Working on What Works," to improve classroom culture.

Linda Metcalf Linda Metcalf applies solution-focused counseling in school contexts, including solution-focused school counseling (Metcalf, 2008), solution-focused children's groups (Metcalf, 2007), solution-focused parenting (Metcalf, 1998), and solution-focused teaching (Metcalf, 2003).

John Murphy A former high school teacher with training as a school psychologist, John Murphy (2008) trained with Barry Duncan and eventually developed his approach for using solution-focused therapy ideas in school contexts.

Big Picture: Overview of Counseling Process

Solution Building

The process of solution-based counseling is described as *solution building* rather than problem solving, highlighting that the problem is not necessarily related to the solution

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(De Jong & Berg, 2002). By design, the solution-building process is brief and forward-focused. "Brief" can mean as few as one to ten sessions or it might imply a year or more, depending on the severity of the problem, client resources, and numerous other factors (O'Hanlon & Weiner-Davis, 1989). The process focuses on identifying where the client wants to go (the solution) rather than trying to analyze and troubleshoot the problem. For example, rather than identify the cause of depression, the focus is on identifying what life would look like without depression and start taking steps to move in that direction.

After a relatively brief assessment phase, solution-based counselors quickly move to helping clients take *small action steps* between sessions to help clients move toward their identified solutions. These steps are practical and small enough to be achievable between sessions, such as call a friend to go to lunch, exercise three days a week, or go on a date night with a partner. Thus, most weeks, clients leave with some sort of homework assignment or task that involves taking action toward the identified solutions. An important part of the counselor's role is to help motivate the client to take these action steps, and this requires working closely with the client to develop meaningful goals and tasks. A less obvious part of this process is that in session, counselors ask questions and offer observations that shift *how* clients think about their situation so that they move from a problem focus to a perspective that emphasizes resources, strengths, abilities, possibilities, and the future. In general, counselors maintain an upbeat, hopeful attitude in session. In the closing phase of the counseling process, counselors work with clients to identify strategies for managing future problems using the newly acquired resources and strategies.

Making Connection: Counseling Relationship

Optimism and Hope

Signature characteristics, optimism and hope are immediately and undeniably palpable in solution-based counseling (Miller, Duncan, & Hubble, 1996; Miller et al., 1997). Solution-based counselors assume that change is inevitable and that improvement—in some form—is always possible, and they clearly communicate this verbally and nonverbally to clients (O'Hanlon & Weiner-Davis, 1989). Their optimism and hope do not stem from naïveté but rather are grounded in their ontology and epistemology: their theory of what it means to be human and how people learn. Because change is always happening—moods, relationships, emotions, and behaviors are in constant flux—*change is inevitable* (Walter & Peller, 1992). They have hope that the change will be positive because the client is in therapy to make an improvement and because over 90% of clients report positive outcomes in psychotherapy (Miller et al., 1997). Hope is cultivated early in therapy to develop motivation and momentum (Bertolino & O'Hanlon, 2002).

Carl Rogers with a Twist: Channeling Language

O'Hanlon and Beadle (1999) describe how they build counseling relationships by reflecting feelings, similar to Carl Rogers but with a twist. The solution-oriented twist is that their reflections *delimit* the difficult feeling, behavior, or thought by reflecting on a time, context, or relational limit. Such reflections generally use one or more of three strategies for delimiting the problem:

1. *Past tense:* Rather than describe a person's mood as a chronic state or characteristic, reflect statements back to clients in the *past tense* (e.g., "You were feeling down *yesterday*").
2. *Partial:* Rather than using global descriptions of people, situations, or things, describe these as *partial* or *periodic* (e.g., "A *part of you* thinks things will never get better").
3. *Perception:* When a client makes an unhelpful global truth statement (e.g., "Life will never get better"), reflect back the sentiment as a *perception* (e.g., "Right now *it seems to you* that things will never get better").

For example, a client-centered reflection with a client who is telling a story about how her boyfriend got angry at her for "no reason" would be something like "You aren't feeling understood" (present-focused statement about client's unexpressed emotion), whereas

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the solution-focused twist to delimit would be "you were not feeling understood *by your boyfriend last Saturday.*" The solution-oriented twist emphasizes the limited time and relational context in order to (a) define the problem in more solvable ways and (b) engender hope. O'Hanlon and Beadle (1999) refer to this process as "channeling language." By channeling a client's language while listening to the client's story, both the client and the counselor transition more easily to identifying desired outcomes. Channeling language is actually a very difficult skill to develop because it requires a paradigm shift in how the counselor listens for problems and strengths, but with practice it becomes habit.

Beginner's Mind

O'Hanlon and Weiner-Davis (1989) use *beginner's mind* when forming a relationship, referring to the classic Zen saying, "In the beginner's mind there are many possibilities; in the expert's mind there are few" (p. 8). Assuming a position of beginner's mind involves listening to each client's story as if you are listening for the first time, not filling in blanks with personal or professional knowledge. Most counselors underestimate how hard this is to do. When a client starts talking about "feeling depressed," most clinicians believe they have useful diagnostic information, unthinkingly assuming that clients have read diagnostic manuals and use the term as a professional would. In contrast, solution-oriented counselors bring a beginner's mind to the conversation and are curious about *how this person experiences his or her unique depression.* If you get in the habit of asking, you will find that every depression is surprisingly "one of a kind." Thus, solution-oriented counselors make no assumptions when they are listening, asking to hear more about clients' unique experiences and understandings.

Echoing Client's Key Words

Solution-based counselors carefully attend to *client word choice* and echo their key words whenever possible (De Jong & Berg, 2002). For example, rather than teaching clients to use psychiatric terms such as "depression" or "hallucinations" to describe their experience, the counselor prefers to use the client's own language, such as "feeling blue" or "schizos." Using client language often makes the problem more "solvable" and engenders greater hope. For many, "ending the blahs" or "getting back to my old self" is a more attainable goal than treating a psychiatrically defined problem of "296.22 Major Depressive Disorder, Single Episode, Moderate."

The Viewing: Case Conceptualization

Introduction to Solution-Based Case Conceptualization

Unlike most forms of counseling, solution-based counseling primarily involves conceptualizing *where to go from here* (i.e., the solution) rather than where the client has been (i.e., the problem). A basic tenet of solution-based counseling is that *the solution is not necessarily related to the problem*, and thus the solution—where to go—is the focus of assessment (de Shazer et al., 2007). This does not mean that the past is ignored; instead, it is discussed only as long as is necessary to better understand the potential solution. Outside of exceptions (see "Exceptions, Previous Solutions, and 'What Works' "), the past is not the focus of the assessment and case conceptualization process.

The Miracle and Other Solution-Generating Questions

The original solution-generating question, the *miracle question* serves to both (a) conceptualize and assess and (b) set goals in solution-based counseling. Legend (and good authority) has it that Insoo Kim Berg developed the miracle question based on a client's desperate and exasperated claim to Insoo that "maybe only a miracle will help." So, Insoo, using the clients' language and worldview, played with the idea and had clients describe how life would be if there were a miracle (de Shazer, 1988; de Shazer et al., 2007). The intervention was so successful that it was crafted into a hallmark intervention frequently used early in treatment to identify the focus of treatment. Since then, several variations have been developed, including the crystal ball technique (de Shazer, 1985), magic wand questions (Selekman, 1997), and the time machine (Bertolino & O'Hanlon, 2002). When successfully

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delivered, these questions help clients envision a future without the problem, generating hope, motivation, and goals.

- *Miracle question:* Imagine that you go home tonight, and during the middle of the night a miracle happens: all the problems you came here to resolve are miraculously resolved. However, when you wake up, you have no idea a miracle has occurred. What are some of the first things you would notice that would be different? How would you know that the problems that brought you here were resolved?
- *Crystal ball question:* Imagine I had a crystal ball that allowed us to look into the future to a time when the problems you came here for are already resolved. I hold it up to you, and you look in. What do you see?
- *Magic wand question:* Imagine we had a magic wand (or imagine that this magic wand I have here actually works), and you could wave it and all of the problems you came here for are miraculously resolved. What would be different?
- *Time machine:* Imagine I had a time machine that could propel you into the future to the point in time when the problems you came to see me for are totally resolved. Imagine you stepped in: Where do you end up? Who is with you? What is happening? How is your life different? How did your problems go away?

Successfully delivering one of these solution-generating questions is far more difficult than it appears. As you can imagine, if done poorly, these hit the floor like a lead balloon. To avoid such humiliation, solution-focused experts have several suggestions for successfully delivering the miracle question (Bertolino, 2010; Bertolino & O'Hanlon, 2002: De Jong & Berg, 2002; de Shazer, 1988; de Shazer et al., 2007). Additionally, I suggest you think of the asking of the miracle question as having three specific phases:

- Phase 1: Setup for the Miracle
- Phase 2: Delivery of the Miracle Question
- Phase 3: Facilitation of the Answer

Phase 1: Setup for the Miracle: 3 Steps with 3 Nods

- *Phase 1-Step 1: Obtain Client Agreement and Wait for Nod #1:* The first and most critical step is to prepare clients by changing their state of mind so that they are willing to engage in an atypical conversation. By asking, "May I ask an unusual question?" or "Would you be willing to play along if I ask a somewhat odd question?" The counselor signals clients to change their frame of mind so that they are better able to enter a more fanciful, creative conversation. The counselor waits for the client to say "okay" or nod in agreement.
- *Phase 1-Step 2: Custom Tailor Initial Setup and Wait for Nod #2:* After the client agrees to the odd question, begin delivering the question but customize it to include numerous little details from the client's everyday life to get him or her fully engaged in the story and enable him or her to better visualize the miracle. For example, you might say, "Let's imagine that after we are done talking here, you get in your car and drive home; you make dinner for the family like you usually do; you clean up dishes like you usually do; and check the kids' homework like you usually do." *Continue describing the typical day and evening until the client starts to nod.*
- *Phase 1-Step 3: Setup for Miracle and Wait for Nod #3:* Once the client nods, continue with, "Then you get the kids to bed, maybe do some minor chores or watch television, and then you finally get to bed and fall asleep." Up to this point, you have only asked the client to imagine a regular day, but this is very important. The goal is to have the client psychologically leave the session and vividly envision being at home where the miracle is to occur. *Pause and wait for the nod or verbal affirmation before moving on to the miracle; don't move on to the miracle without such confirmation.*

Phase 2: Deliver the Miracle Question: 4 Steps with 3 Pauses and a Snap

- *Phase 2-Step 1: Introduce the Miracle with Pause #1:* "Then, during the night ... while you are sleeping ... a miracle happens" (de Shazer et al., 2007, p. 42). Pause

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and wait for a reaction that signals surprise or that they are thinking: a smirk, laugh, tilting of the head, raised eyebrow, or funny look. Insoo reportedly looks intently at the client and smiles; Steve warned that if you pause for too long, the client is likely to respond with, "I don't believe in miracles"; so keep moving.

- *Phase 2: Step 2: Specifically Define the Terms of the Miracle with Optional Snap:* "And it's not just any miracle. This miracle makes the problems that brought you here today disappear ... just like *that*" (de Shazer et al., 2007, p. 43; emphasis in the original). Snapping your fingers at this point is optional but adds flair (you might need extra practice with that part). If you forget to include the "problems that brought you here" part of the question, you most likely will get a wish list appropriate for a genie in a lantern, which is not the answer we want for this question. Without this limit on the miracle, clients will spend a lot of time exploring vague and unrelated goals, and the counselor will spend more time with follow-up questions to get a useful answer.
- *Phase 2-Step 3: Add Mystery with Pause #2:* "However, because you were sleeping, you don't know that *the miracle has happened*" (De Jong & Berg, 2002, p. 85). If delivered well, most clients start bobbing their heads at this point, stare off into space, or otherwise begin to behave as if they were thinking about the proposition.
- *Phase 2-Step 4: Ask What Is Different with Pause #3:* "So, you wake up the morning after the miracle happens during the night. All the problems that brought you here are gone—poof—just like that. What is the very first thing you notice after you wake up? What are the little changes you start to notice that tell you the problem is gone?" (de Shazer et al., 2007, p. 43). At this point, many clients need some time to think about their answer, often becoming quiet, still, and pensive. This is generally a sign that the client is generating new ideas, so it is important that the counselor patiently *wait* for the response. Rushing clients at this point will likely generate more-of-the-same thinking.

Phase 3: Facilitating the Description of the Miracle: 2 Steps with one List

- *Phase 3-Step 1: Focus Client on Behavior Changes in Positive Language:* Those new to this intervention often imagine their work is done once the question has been asked. For the miracle question to be useful in case conceptualization, the counselor needs to skillfully facilitate the description of the miracle—not just any miracle will do. Once the client begins to describe what is different, the counselor helps focus the answer by asking about *observable behavioral changes* in the client and others. In typical solution-focused style, the counselor is interested not in what the client is *not* doing but instead in what the client *is doing*. For example, if the client says, "I will not be depressed any more," the counselor responds with, "What will you be doing instead?"
- *Phase 3-Step 2: Continue Until You Have Enough to Identify Clear Goals:* Once the client identifies one new behavior, the counselor asks for more: "What else would be different?" The counselor continues until several (three or more) concrete miracle behaviors are identified that can be useful for developing goals and clear direction for change. In the case study at the end of this chapter, the counselor uses the miracle question with Marcella to identify what "getting over" sexual abuse will look like for her, which included having a relationship with her parents and pursing her dream to become a pediatrician.

Try It Yourself

Find a partner and take turns asking the miracle question. What helps the client get into the right frame of mind for this question?

Exceptions, Previous Solutions, and "What Works"

Successful solution-based counseling requires developing an uncanny, sleuthlike ability to detect even the minutest exceptions to problems (this is generally an endearing quality in

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personal relations by the way, so it is worth cultivating). Solution-based counselors assess for *exceptions*, *previous* (helpful) *solutions*, and examples of *what works* in three different ways: (a) as part of the follow-up to the miracle question, (b) listening for spontaneous descriptions of exceptions, and (c) directly asking about exceptions (de Shazer, 1985, 1988; de Shazer et al., 2007; O'Hanlon & Weiner-Davis, 1989). First, if the miracle or other solution-generating question has been used, exceptions can be identified by asking, "What elements of the miracle are happening now, even just a little?" This prompt often results in a heartening description for both client and counselor of what elements of the miracle are already there; most are thrilled to think that half (or 25%) of the work is already done. Alternatively, the finely tuned solution-focused ear attends to clients' spontaneously offered descriptions of exceptions and examples of what works: "Except for when I am on my boat, I am always depressed" or "The only time I don't worry is when I am playing with my kids" or "Suzy is the only one who cares about me." These seemingly minor exceptions provide clues as to what works and therefore what clients need to do more frequently. Additionally, solution-based counselors directly ask about exceptions to gather more information about what works:

Examples of Exception Questions

- Are there any times when the problem is less likely to occur or be less severe?
- Can you think of a time when you expected the problem to occur but didn't?
- Are there any people who seem to make things easier?
- Are there places or times when the problem is not as bad?

The vast majority of clients will be able to identify exceptions with questions such as these: note that the assumption underlying most of these questions is that the problem varies in *intensity*; the times when the problem is *less severe* is considered a type of exception and generally provides clues as to what works (de Shazer, 1985; O'Hanlon & Weiner-Davis, 1989). Especially true with diagnoses such as depression that are experienced most of the time most days, counselors need to focus on identifying the varying of intensity rather than the absence of the symptom to identify exceptions.

Try It Yourself

Find a partner and take turns asking exception questions and identifying when the problem is less of a problem. Did any ideas emerge for how to improve the situation?

Pre-session Change

Solution-based counselors pay careful attention to *pre-session change:* change that occurs *after* the initial phone call to make an appointment and *before* the first session (de Shazer et al., 2007). Counselors can assess this by asking, "Since we spoke on the phone (or you made the appointment), what changes have you noticed that have happened or started to happen?" In early research surveys, Weiner-Davis, de Shazer, and Gingerich (1987) reported that the majority of clients reported *some* positive changes *before* the first changes, leading them to hypothesize that simply the anticipation of change and making a commitment to change (i.e., an appointment with a professional) mobilizes clients resources and begins the change process. This question is asked *very early* in the first session to assess for what works, strengths, and resources.

Assessing Client Strengths

Assessing client strengths is one of the key areas of assessment in solution-based counseling (Bertolino & O'Hanlon, 2002; De Jong & Berg, 2002; O'Hanlon & Weiner-Davis, 1989). Strengths include resources in a person's life, personally, relationally, financially, socially, or spiritually, and may include family support, positive relationships, and

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religious faith. Most counselors *underestimate* the difficulty of identifying strengths. In fact, identifying client strengths is often *harder* than diagnosing pathology because clients come in with a long list of problems they want fixed and are thus prepared to discuss pathology. Surprisingly, many clients, especially those with depressive or anxious tendencies (the majority of outpatient cases), have great difficulty identifying areas without problems in their lives. Similarly, many couples who have been distressed and arguing for long periods of time have difficulty identifying positive characteristics in their partners, happy times in the marriage, and, in the most desperate of cases, the reasons they got together in the first place. Therefore, counselors often have to ask more subtle questions and attend to vague clues in order to assess strengths well.

Solution-based counselors assess strengths in two ways: (a) by directly asking about strengths, hobbies, and areas of life that are going well and (b) by listening carefully for *exceptions* to problems and for areas of unnoticed strength (Bertolino & O'Hanlon, 2002; De Jong & Berg, 2002). Furthermore, I have found that any strength in one context has the potential to be a liability in another context and that the inverse is also true: any weakness in one area is generally a *strength* in another area (see the section "Assessment of Strengths and Diversity" in Chapter 16). Therefore, if a client has difficulty identifying strengths and more readily discusses weaknesses and problems, a fine-tuned solution-focused ear will be able to identify potential areas in which the weakness is a strength. For example, a person who is critical, anxious, and/or negative in a relational context typically excels at detailed or meticulous work and tasks. This insight can be useful in identifying ways for clients to move toward their goals.

Solution-based counselors have been on the vanguard of a larger movement within mental health that emphasizes identifying and utilizing client strengths to promote better clinical outcomes (Bertolino & O'Hanlon, 2002). Increasingly, county mental health offices and insurance companies are requiring assessment of strengths as part of initial intake assessments. The key to successfully assessing strengths is the unshakable belief that *all* clients have significant and meaningful strengths no matter how dire and severe their situations appear in the moment. It is helpful for counselors to remember that we see people typically in their worst moments; therefore, even if we are not seeing strengths in the moment, they are undoubtedly there. Solution-based counselors maintain that all people have strengths and resources and make it their job to help identify and utilize them toward achieving client goals.

Client Motivation: Visitor, Complainant, and Customers

Steve de Shazer (1988) assessed client motivation for change using three categories: visitors, complainant, and customers. These categories are used to understand the type of *relationship* the counselor has with the client rather than to label the client (De Jong & Berg, 2002):

- *Visitor-type relationship:* In this relationship, the client does not have a complaint, but generally others have a complaint against him or her. These clients are typically brought to therapy by an outside other, such as courts, parents, or spouse. They are often most motivated to get the third party "off their back"; thus, the counselor should honor this and quickly identify the specific goals that would achieve this end, making calls to probation officers and social workers as necessary.
- *Complainant-type relationship:* In this type of relationship, the client identifies a problem but expects the counselor or some other person to be the primary source of change. Rather than try to convince these clients to change their perspectives, the solution-focused counselor works with these clients to identify small ways they can positively affect the situation.
- *Customer-type relationship:* In this type of relationship, the client and counselor jointly define a problem and solution picture, and the client is motivated to take action toward the solution.

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	Visitor Type	Complainant Type	Customer Type
Motivation	Low	Moderate to high	High
Source of problem or solution	Outside other (spouse, parent, court) thinks client has a problem.	Problem generally related to outside cause or person; expect counselor or another to be source of solution.	Self as part of problem and active agent in solution.
View of who needs to change	Outside other needs to see there is no problem.	Outside other needs to change and/or fix it.	Self needs to take action to fix things.
Building therapeutic alliance	Identify areas where client sees problem willing to work on to make them a customer for change.	Honoring client's view of the situation while identifying specific instances where client can make a difference.	Join with client by complimenting readiness for change.
Focus of interventions	Building alliance; understanding client perspective; framing outside request for change as the problem.	Observation-oriented tasks (e.g., identifying exceptions over week; Selekman, 1997, 2010).	Reframing; identifying what does not work; action-oriented tasks.
Readiness for action	Not ready for making active changes in life until client believes there is a problem and is motivated for change.	Not ready for action until open to the idea that their actions can make a difference.	Ready to take action to make changes.

Assessing clients' motivation is helpful in knowing how to build relationships with the client and how to proceed. Many new counselors assume that all clients are customers for change: ready to take action to improve their situation simply because they showed up for a therapy session. However, this is often not the case. People come to therapy with mixed emotions and varying levels of motivation. Generally, most mandated clients are "visitors," and counselors need to find a way to connect with their agenda while still working with the referring party's agenda. This same dynamic is often the case with children, teens, and even one-half of a couple. In complainant relationships, counselors need to either find ways that the client can contribute to making a difference or help shift the viewing of the problem to increase client willingness to take action. In the case study at the end of this chapter, Marcella begins as a complainant, feeling as though the problem was her brother's death and sexual abuse; however, she is quickly able to identify changes she wants and can make, making her a customer for change.

Details, Details, Juicy Details

Throughout the assessment and case conceptualization process, solution-focused counselors are continually asking about the *details*: who, what, where, why, and when.

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Effective "solution building requires getting details, details, and more details" (De Jong & Berg, 2002, p. 24). By learning more about when symptoms are better or worse, who is around when things are better or worse, and what happens step by step when things get a little better, counselors become well provisioned for helping to build solutions. For example, when a client reports that the depressed feelings are reduced at work or when busy (very common), the counselor asks about the details of what happens in these contexts to identify potential elements of solutions, such as being around people or away from people, having a purpose, being outside, avoiding thinking about another problem, and so on.

Targeting Change: Goal Setting

Goal Language: Positive and Concrete

Solution-based counselors state their goals in positive, observable terms (De Jong & Berg, 2002). Positive goal descriptions emphasize what the client is *going to be doing* rather than focusing on symptom reduction, which is typical in pathology-focused counseling approaches. Observable descriptions include clear, specific behavioral indicators of the desired change.

Positive, Observable Goal Example	Negative (Symptom Reducing), Nonobservable Goal Examples
Increase periods of engaging in hobbies and enjoyable activities	Reduce depression
Increase sense of confidence and calm in social situations	Reduce panic attacks
Increase frequency of choosing healthy foods and healthy portions	Reduce binging and purging

You may have noticed that simply reading the left column generates more hope and provides greater direction for clinical intervention than the right column. Positive, observable goals provide a constant reminder to the counselor and client of the goal and reinforce a solution-focused and solution-oriented perspective. Many solution-based techniques, such as scaling questions (see "Scaling Questions"), invite the client to measure goal progress weekly; thus, carefully crafted goal language is particularly critical to success in solution-based counseling.

Additional qualities of solution-based goals include the following (Bertolino & O'Hanlon, 2002; De Jong & Berg, 2002):

- *Meaningful to client:* Goals must be *personally* important to the client, not just a "good idea."
- *Interactional:* Rather than reflect a general feeling (e.g., "feeling better"), the goals should describe how interactions with others will change.
- *Situational:* Rather than global terms, goals are stated in situational terms (e.g., improved mood at work).
- *Small steps:* Goals should be short-term and with identifiable small steps.
- *Clear role for client:* Goals should identify a clear role for the client rather than for others.
- *Realistic:* Goals need to be realistic for this client at this time.
- *Legal and ethical:* Goals should be legal and adhere to client, counselor, and professional ethics.

One Thing Different

In the beginning, goals should focus on doing one small thing differently rather than target broad, lofty goals (e.g., call a friend this week rather than visit with someone

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everyday; de Shazer, 1985, 1988; O'Hanlon, 2000; O'Hanlon & Weiner-Davis, 1989). Similarly, a goal such as "get up and exercise one day this week" rather than every day this week is more likely to generate change and motivation for further action. In most cases, making this *one small change* starts a cascade of change events that are inspired from the client's *own* motivation rather than the prescription of the counselor (or even a co-created solution with the counselor). Ideas generated in therapy are not viewed as the "best," "only," or "correct" solution but rather as activities that will spark clients to identify what works for them.

The Doing: Interventions

Solution-Focused Tenants for Intervention

De Shazer et al. (2007, p. 2) identify basic tenets of solution-focused intervention that counselors can use to guide their work:

1. *If it isn't broken, don't fix it:* Don't use therapeutic theory to determine areas of intervention.
2. *If it works, do more of it:* Amplify and build on things that are currently working.
3. *If it's not working, do something different:* Even if it's a good idea, if it's not working, find another solution.
4. *Small steps can lead to big changes:* Begin with small doable changes; these typically happen and quickly lead to more change.
5. *The solution is not necessarily related to the problem:* Focus on moving forward, not understanding why there is a problem.
6. *The language for solution development is different from that needed to describe a problem:* Problem talk is negative and past-focused; solution talk is hopeful, positive, and future-focused.
7. *No problem happens all the time; there are always exceptions that can be utilized:* Even the smallest exception is useful for identifying potential solutions.
8. *The future is both created and negotiable:* Clients have a significant role in designing their future.

Scaling and Miracle Questions

Described in "The Juice," scaling and miracle questions are the bread-and-butter techniques for week-to-week interventions. They can be used to (a) assess whether the last week's tasks were helpful, (b) identify potential areas for change, and (c) develop specific homework tasks for the following week.

Formula First Session Task

As the name implies, the *formula first session task* (de Shazer, 1985) is typically used in the first session with all clients, regardless of issue, to increase clients' hope in the therapy process and motivation for change.

> *Formula First Session Task:* "Between now and the next time we meet, we [I] would like you to observe, so that you can describe to us [me] next time, what happens in your [pick one: family, life, marriage, relationship] that you want to continue to have happen" (de Shazer, 1985, p. 137).
>
> *Formula First Session Task (paraphrased with introduction):* "As we are starting therapy, many things are going to change. However, I am sure that there are many things in your life and relationships that you do *not* want to have changed. Over the next week, I want you to generate a list of the things in your life and relationships that you *do not* want to have changed by therapy. Notice small things as well as big things that are working right now."

This directive stimulates clients to notice what is working and to identify their strengths and resources and helps generate hope and agency.

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Presuppositional Questions and Assuming Future Solution

Presuppositional questions and talk that assume future change help clients envision a future without the problem, generating hope and motivation (O'Hanlon & Beadle, 1999; O'Hanlon & Weiner-Davis, 1989). Solution-focused counselors assume change based on the observation that all things change: a client's situation *cannot not* change. Knowing that change is inevitable and that most clients benefit from therapy, counselors can be confident when they ask presuppositional questions such as the following:

- What will you be doing differently once we resolve these issues?
- Do you think there are other concerns you will want to address once we resolve these issues?
- When the problem is resolved, what is one of the first things you will do to celebrate?

Questions such as these can be very helpful in cases where clients feel hopeless or have difficulty imagining a future without the problem.

Videotalk

Videotalk is a technique that distinguishes between two basic levels of experience: (a) *facts* and (b) *stories and experience* (Hudson & O'Hanlon, 1991). The *facts* are a behavioral description of what was done and said—what would be recorded on videotape (hence the name). The *story* is the interpretation and meaning that a person associates with the behaviors and words, while the *experience* is a person's internal thoughts and feelings. The overarching goal of videotalk is to separate out facts (what behavior happened) from interpretation (stories and subjective experience in response to what happened). By separating what happened from how clients interpret the events, counselors and clients can closely examine how meanings were made and responses created, allowing new understandings and responses.

Anatomy of Videotalk: Facts versus Interpretation

- *Facts:* What is captured by video camera; *behavioral description* of what was said and done.

Examples:

"If I had a video camera, what would I see you do or say when you are feeling depressed?"

"If I had a video camera, what would I see you do or hear you say the day of your miracle?"

- *Interpretations:* Description of the *stories* (interpretations) and subjective *experiences* (what was thought and felt)

Examples:

"When you are lying in bed not wanting to get up, what are you thinking and feeling? What type of meaning do you make of this situation and who you are because of it?"
"When you are getting up before the alarm rings and going for a run, what are you thinking and feeling? What type of meanings are you making about yourself and your choice to get up and run before the alarm goes off? How do you feel about yourself?"

Try It Yourself

Find a partner and take turns using videotalk to describe a problem situation or interaction. How does separating out the behavior from the interpretation change how you understand the situation?

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When a client reports vague feelings or goals, counselors can help them bring greater clarity to and descriptions of the problem and solution by using videotalk. These descriptions are used to define the problem behaviorally and identify potential solutions using small weekly behavioral tasks. In addition, solution-oriented counselors prefer to use the descriptive language of videotalk to describe problems and solutions (e.g., "wanting to sleep in" or "when you are running in the mornings again") rather than vague interpretation or experience labels, such as "depressed" or "feeling better." When counselors consistently use videotalk to separate the *behaviors* from *interpretation of the behaviors*, clients are better able to identify where and how to make changes. For example, in the case study at the end of this chapter, the counselor uses videotalk to help Marcella identify how she can more effectively interact with her parents who disapprove of her sexual orientation.

Utilization

Based on the hypnotic work of Milton Erickson, de Shazer (1988) employed *utilization* techniques to help clients identify and enact solutions. Utilization refers to finding a way to use and leverage whatever the client presents as a strength, interest, proclivity, or habit to develop meaningful actions and plans that will lead in the direction of solutions. For example, if a client has difficulty making friends and close relations but has numerous pets, the counselor would utilize the client's interest in animals to develop more human connections, perhaps by taking a dog for a walk in public places, joining a dog agility class, or volunteering at a pet shelter.

Coping Questions

Coping questions generate hope, agency, and motivation, especially when clients are feeling overwhelmed (De Jong & Berg, 2002; de Shazer et al., 2007). They are used when the client is not reporting progress, describing an acute crisis, or otherwise feeling hopeless. Coping questions direct clients to identify how they have been coping through a current or past difficult situation:

- "This sounds hard—how have you managed to cope with this to the degree that you have?" (de Shazer et al., 2007, p. 10)
- "How have you managed to prevent the situation from getting worse?" (p. 10)

Compliments and Encouragement

Solution-based counselors use compliments and encouragement to motivate clients and highlight strengths (De Jong & Berg, 2002). The key with compliments is to compliment *only* when clients are making steps toward goals *that they have set or compliment specific strengths that relate to the problem.* This is so important that I am going to say it again and put it in a special box so you don't forget:

How to Compliment Clients

Compliment only when clients are making steps toward goals that they *have set or compliment specific strengths that relate to the problem; compliment* their progress, *not their personhood.*

Basic therapeutic compliment:

- "Wow. You made real progress toward your goal this week."

Even better therapeutic compliment:

- "I am impressed; you not only followed through on the chart idea we developed last week but you also came up with your own additional strategies—setting up a weekend outing with his friend—to improve your relationship with your son." (compliment specific behavior toward goal)

(*continued*)

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Not-so-therapeutic compliments:

- "I really admire what you have done with your life." (too personal and does not clearly relate to the problem; sounds like you are "buttering up" client)
- "You really are a great mom." (nonspecific; evaluating mothering skills globally; not allowing client to reflect on and evaluate his or her own behavior)

When you compliment on anything else, you are setting up a situation where you are rendering judgment, albeit a positive one, on the client and/or his or her life. Compliments should not be used to be nice to clients (De Jong & Berg, 2002). Instead, compliments should be used to reinforce progress toward goals that clients have set for themselves and stated in such a way that they encourage clients to validate themselves rather than rely on an outside authority figure to do so. When clients can set goals and make progress toward them, they develop a greater sense of *self-efficacy*, which is a greater predictor of happiness than self-esteem (Seligman, 2004).

Homework and Experiments

Just in case it hasn't been obvious, almost every week solution-based counselors assign a homework assignment or task that requires the clients to take small, concrete steps toward their desired goals. These tasks are collaboratively identified during session using any number of techniques listed earlier. The counselor's role is to help define the task concretely so that the client (a) knows exactly what to do, (b) is motivated to do it, and (c) is likely to succeed. To ensure success, counselors should also identify potential obstacles, including weekends, holidays, visitors, schedule changes, and so on, or anything that might keep clients from attaining their goals.

Interventions for Specific Problems

Sexual Abuse

Dolan (1991) and O'Hanlon and Bertolino (2002) use solution-based counseling with child and adult survivors of childhood sexual abuse. Solution-based approaches stand out from traditional approaches to sexual abuse treatment in their optimistic and hopeful stance that emphasizes the resiliencies of survivors. Given that survivors of sexual abuse have *survived* such a difficult trauma, solution-oriented counselors harness those strengths in new ways to help them resolve current issues. Some of the distinctive qualities of solution-oriented approaches to treating sexual abuse include the following:

Honoring the Agency of Survivors More so than in traditional approaches, solution-based counselors honor the agency of survivors, allowing them to decide whether to tell their abuse stories and determine the pacing of their treatment (Dolan, 1991; O'Hanlon & Bertolino, 2002). Although many counselors insist that a survivor cannot heal without sharing the details of their abuse to their counselors, solution-based counselors would not readily agree. Instead, solution-based counselors work with clients to identify if, when, how, and to whom it is best to tell their stories. By fully honoring their agency, counselors create a relationship in which survivors reclaim full authority over the private aspects of their lives, reclaiming autonomy that was lost through the abuse. Counselors who play a more directive role in working with a survivor may unintentionally replicate the abuse pattern by forcing clients to reveal parts of their sexual life in the name of "treatment" before the client is ready, leaving the client feeling violated and retraumatized.

The Recovery Scale: Focusing on Strengths and Abilities Dolan (1991, p. 32) uses the *Solution-Focused Recovery Scale* to identify areas of the client's life that were not affected by the abuse, reducing the sense that the client's whole life and self have been affected. The success strategies in these areas are used to address areas that are affected

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by the abuse. Questions from this scale are rated "not at all," "just a little," "pretty much," and "very much," and include questions such as the following:

- Able to think/talk about the trauma
- Feels part of family
- Goes to work
- Cares for pets, plants
- Holds hands with loved one
- Able to relax without drugs or alcohol
- Accepts praise well
- Shows healthy appetite

3-D Model: Dissociate, Disown, and Devalue O'Hanlon and Bertolino (2002) conceptualize the aftereffects of abuse and trauma using the *3-D Model*, which postulates that abuse leads people to *dissociate*, *disown*, and *devalue* aspects of the self. The goal of counseling is to reconnect people with these disowned parts, parts that tend to either inhibit experience (e.g., lack of sexual response, lack of memories, or lack of anger) or create intrusive experiences (e.g., flashbacks, sexual compulsions, or rage). O'Hanlon and Bertolino (2002) note that many of the symptoms related to sexual abuse are experienced as a sort of *negative trance*, feeling as though the experience is uncontrollable and involving only a part of the self. Solution-oriented counselors use *permission* (i.e., allowing clients to express and feel undesirable feelings), *validating* (i.e., helping clients acknowledge difficult or unwanted feelings), *and inclusive language* (i.e., creating space for contradictory parts or feelings to be simultaneously recognized) to encourage clients to revalue and include the devalued aspects of self that were disowned through the abuse.

Constructive Questions Dolan (1991, pp. 37–38) uses constructive questions to construct solutions by identifying the specifics of clients' unique solutions:

- What will be the first (smallest) sign that things are getting better, that this (the sexual abuse) is having less of an impact on your current life?
- What will you be doing differently when this (sexual abuse trauma) is less of a current problem in your life?
- What will you be doing differently with your time?
- What will you be thinking about (doing) instead of thinking about the past?
- Are there times when the above is already happening to some (even a small) extent? What is different about those times? What is helpful about those differences?
- What differences will the above healing changes make when they have been present in your life over an extended time (days, weeks, months, or years)?
- What do you think your (significant other) would say would be the first sign that things are getting better? What do you think your significant other will notice first?
- What do you think your (friends, boss, significant other, etc.) will notice about you as you heal even more?
- What differences will these healing changes you've identified make in future generations of your family? (p. 37–38)

Videotalk (Action Terms) with Abuse and Trauma Survivors Because of the intense emotions that characterize abuse and trauma, survivors often have difficulty identifying the current effects of abuse in their present life. O'Hanlon and Bertolino (2002) use videotalk (see preceding text) with survivors to help identify specific actions and patterns of behavior that recreate the traumatic experience, including the sequence of events, antecedents, consequences, invariant actions, repetitive actions, and body responses. Once these recurrent patterns are identified, counselors help clients either change one part of the context to interrupt the cycle and create space for new responses or, if the client feels a certain degree of control over the symptoms, identify new, alternative

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solution-generating actions. For example, if a client gets flashbacks when watching sexual scenes in movies, the counselor helps identify the behaviors before and after the flashbacks as well as the thoughts, feelings, and interpretations of these events. Using this information, such as the client's anxiety building as the suspense builds in the movie, the counselor can help the client identify ways to interrupt the cycle by hitting the mute button, turning on the lights, or going for a bathroom break.

Putting It All Together: Solution-Based Treatment Plan Case Conceptualization and Treatment Plan Templates

Theory-Specific Case Conceptualization: Solution-Based

Use the prompts below to develop a theory-specific case conceptualization; the case study at the end of the chapter provides an example.

- *Strengths:* Describe unique client strengths, including:
  - Personal strengths and abilities
  - Relational and social strengths and resources
  - Spiritual resources
- *Exceptions, Previous Solutions, and What Works:* Describe times, places, relationships, contexts, and so on, when the problem is less of a problem or when things are even slightly better.
- *Miracle Question Answer:* Identify what client will be doing differently when the problem is resolved.
- *Client Motivation:* Describe client's level of motivation: visitor, complainant, or customer for change.
- *Solution-Focused Description of Problem and/or Solution:* Describe problem using solution-focused language that avoids pathologizing language and negative labels and instead highlights concrete behaviors that need to be changed and/or new behaviors to be adopted. The solution-focused language should be detailed and inspire hope and/or a positive vision of change.

Treatment Plan Template: Solution-Based

Use this treatment plan template for developing a plan for clients with depressive, anxious, or compulsive types of presenting problems. Depending on the specific client, presenting problem, and clinical context, the goals and interventions in this template may need to be modified only slightly or significantly; you are encouraged to significantly revise the plan as needed. For the plan to be useful, goals and techniques should be written to target specific beliefs, behaviors, and emotions that the client is experiencing. The more specific, the more useful it will be to you.

Treatment Plan

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration:* [Describe how you will specifically adapt your approach to be sensitive to client diversity when developing the counseling relationship; this may include respecting cultured and gendered norms for emotional expression.]
   Relationship building intervention:
   a. Build rapport by identifying **strengths**, **resources**, and **channeling language** to delimit problem, identify areas of functioning, and generate hope.

(*continued*)

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2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Identify resources related to diversity.
   Assessment Strategies:
   a. **Miracle question** to obtain behavioral description of solutions and motivate clients.
   b. Identify exceptions, previous solutions, "what works," pre-session change, and strengths.

Initial Phase Client Goals* (One to Two Goals): Manage crisis issues and/or reduce most distressing symptoms

1. *Increase* safety and ability to use resources to prevent crisis situations (personal/relational dynamic) to reduce [crisis-related behavior] (symptom).
   Interventions:
   a. Motivate client to use scaling for safety to generate step-by-step safety plan.
   b. Identify personal, relational, and community resources to provide immediate support for client.
   c. Formula first session task to identify what *is* working well right now and to generate hope.

   *Note: Solution-based treatment plans will have *only* goals that begin with "increase" since they use positively stated goals.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* [Describe how you monitor the client's ongoing sense of connection with counselor and how you will specifically adapt monitoring and/or relationship based on client age, gender, cultural, sexual orientation, socioeconomic status, etc.].
   Assessment Intervention:
   a. Session Rating Scale; adjust alliance based on client level of **motivation** (visitor, complainant, or customer); if intervention does not work, **do something different**.

Working Phase Client Goals

1. *Increase* [behaviors derived from "**exceptions**," "**what works**," and/or "**previous solutions**"] (personal/relational dynamic) to reduce depressed mood, anxiety, problem behaviors, and so on (symptom).
   Interventions:
   a. **Scaling questions** to identify specific behavioral tasks each week to generate incremental improvement.
   b. **Coping questions** to augment areas of strength and resource utilization.
2. *Increase* [one set of behaviors identified in **miracle question**] (personal/relational dynamic) to reduce depressed mood, anxiety, problem behaviors, and so on (symptom).
   Interventions:
   a. **Scaling questions** to identify specific behavioral tasks each week to generate incremental improvement.
   b. **Videotalk** to identify specific behaviors and how they inform client's personal and relational identities.
3. *Increase* [another set of behaviors identified in **miracle question**] (personal/relational dynamic) to reduce depressed mood, anxiety, problem behaviors, and so on (symptom).

(*continued*)

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Interventions:

a. **Scaling questions** to identify specific behavioral tasks each week to generate incremental improvement.
b. **Presuppositional questions** to help client envision solution and build hope.

Closing Phase of Treatment

Closing Phase Counseling Tasks

1. Develop aftercare plan and maintain gains. Diversity consideration: [Describe how you will access resources in the communities of which they are a part to support them after treatment ends.]
   Intervention:
   a. Use scaling questions to identify specific behaviors that would signal a setback; develop plan and resources that client could use to handle it.

Closing Phase Client Goals

1. *Increase* confidence and solidify **new identity** related to living the solution (personal/relational dynamic) to reduce depressed mood, anxiety, problem behaviors, and so on (symptom).
   Interventions:
   a. **Compliments and encouragement** to build new identity based on solution behaviors, choices, and so on.
   b. **Scaling questions** to reflect on progress and what worked; discuss how to maintain.
2. Increase use of new skills to **build solutions** in personal, family, interpersonal, and occupational situations (personal/relational dynamic) to reduce depressed mood, anxiety, problem behaviors, and so on (symptom).
   Interventions:
   a. **Compliments and encouragement** of new skills and ability to adapt them to new situations.
   b. **Scaling into the future** to anticipate ups and downs and how to manage.

Solution-Focused School Counseling

School counselors have enthusiastically embraced solution-focused counseling because of its applicability in educational settings (Cooley, 2009; Davis & Osborn, 2000; Kelly et al., 2008; Metcalf, 2003, 2007; Murphy, 2008; Parsons, 2009; Sklare, 2004). The potential to be brief makes solution-focused counseling ideal for implementation in school contexts where counselors often have 5- to 20-minute windows of time in which to do their work. Furthermore, for decades research has shown that students live up (or down) to teacher *expectations*: if a teacher believes a child to be smart and well behaved, more often than not the child lives up to this perception. Thus, if solution-focused methods are used to increase the ability of teachers, students, parents, and administrators to see the strengths of students, this approach can have powerful, long-term, and widespread effects on students in schools (Kelly et al., 2008). Research over the past decade provides support for solution-focused school counseling as a promising approach, particularly to help students reduce the intensity of negative emotions, conduct problems, and externalizing behaviors (Kim & Franklin, 2009).

Assumptions in Solution-Focused School Counseling

Murphy (2008) identifies five assumptions in solution-focused school counseling:

1. If it works, do more of it. If it doesn't work, do something different.
2. Every client is unique, resourceful, and capable of changing.

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3. Cooperative relationships enhance solutions.
4. No problem is constant.
5. Big problems do not always require big solutions.

Solution-Focused Viewing in School Contexts

Many of the conceptualization concepts used in more therapeutic applications of solution-focused work are applied in school contexts.

1. *Behavioral Description of Problem:* Similar to other solution-focused counselors (Bertolino & O'Hanlon, 2002; De Jong & Berg, 2002), the problem is defined in nonpathological, nonblaming terms and languaged to emphasize ways in which the persons involved can effect change (Cooley, 2009; Kelly et al., 2008; Metcalf, 2008). Whenever possible, solution-focused school counselors avoid describing attitude, personality, or mood as the problem; instead, behavioral descriptions (that may be believed to result from these issues) are defined as the problem.
   Example: A seventh grader, Jose:
   - Grades have dropped from As and Bs to Cs and Ds over the past three months.
   - More withdrawn in classes, losing participation and classwork points
   - Hangs out with fewer friends after school or on the weekends
2. *Systemic Maintenance of the Problem:* Drawing on systemic concepts about systemic homeostasis (Watzlawick, Weakland, & Fisch, 1974; see Chapter 11), the counselor, parents, teacher, and student identify what actions are helping to maintain the problem, while minimizing blame. Counselors should explore how *each person* may in some small way collude with the problem, intentionally or unintentionally, to perpetuate the life of the problem.
   Example:
   - Jose watches television rather than doing homework when he gets home.
   - His mother repeatedly tells him to do his homework until he does.
   - Jose says he never had to work this hard in sixth grade, when his grades were good (may need study skills).
   - Jose has fewer classes with his friends this year.
   - Jose's teachers say he's a nice kid but doesn't seem to study or have friends.
3. *Exceptions:* As described initially by de Shazer, (1985, 1988), the counselor helps students, teachers, and parents identify exceptions or when the problem is less of a problem.
   Example:
   - Jose does a good job finishing homework and getting points for that; he has a harder time studying for tests and doing well on tests.
   - Jose likes doing hands-on science projects and enjoys these most.
   - Jose has lunch with a friend some days at school.
   - Jose will talk to other kids in class if he has to for a group assignment.
   - Jose enjoys playing soccer and plays well with siblings.

Solution-Focused Groups in School Contexts

Increasingly, school counselors are asked to create groups for students with particular problems, such as anger, study skills, divorcing parents, and so on (Kelly et al., 2008; Metcalf, 2008). Groups are highly efficient means of providing counseling services, saving both time and money. School counselors use several common solution-focused principles to organize group sessions in a school context, including:

1. *Solution-focused goal setting:* The counselor helps group members define their goals in positive terms (Kelly et al., 2008; Metcalf, 2008), such as "How will you know when things are better for you?" If the student angrily responds, "When my teacher or parent think I am done" or something similar, the counselor goes with it in solution-focused style and asks, "What will you need to be doing for person X to believe you don't need to be here?" Counselors can also use scaling questions (de Shazer, 1994; see "The Juice" above) to establish goals and measure progress from week to week. If the group has met before, the counselor should also follow up on homework tasks and explore where students are on the scale this week.

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2. *Identifying exceptions and strengths:* Using the miracle question (de Shazer, 1985), exception questions (de Shazer et al., 2007; O'Hanlon & Weiner-Davis, 1989), strengths assessment (Metcalf, 2008), and input from group members who know each other or the situation, the counselor helps identify exceptions to help with building solutions. Also, the counselor can point out exceptions and strengths in the group setting, such as noting how the boy who says he is shy is talking quite a bit in the group or how a student referred for aggressive behavior is being cooperative.
3. *Encouraging small changes:* Using the group for support and positive encouragement, the counselor helps to motivate students to make one small change (Metcalf, 2008; O'Hanlon & Weiner-Davis, 1989). A positive group environment can be a remarkable motivator for students to make a turnaround.
4. *Developing concrete out-of-session tasks:* Each week, participants should leave with one clear task for the upcoming week to take a step toward their solutions (Kelly et al., 2008; Metcalf, 2008). These tasks can be small, such as asking one new person to play during recess at least once during the week or doing 15 minutes of homework before watching television after school.

Sample Eight-Session Group

Kelly et al. (2008, pp. 109–110) describe an eight-session template for organizing middle and high school groups to address a specific topic, such as anxiety, divorce adjustment, or grades:

Session 1: Getting Started

- Introductions, informed consent, and group expectations.
- Discuss goals of the group.

Session 2: Goal Setting

- "What do you hope to achieve by participating in this group for eight weeks?"
- Miracle question to identify solutions (if appropriate for age, have students draw miracle).

Session 3: Scaling

- "On a scale from 0 to 10, with 10 being where you want be at the end of this group and 0 being where you were when someone first had the idea to have you join the group, where are you today? What would have to happen for you to move one point up the scale before the next time we meet?"
- Identify specific tasks and behaviors for each student to help them move up the scale.

Session 4: Signs of Success

- Review Session 3 homework assignment, having students identify "signs of success."
- Use relational questions to motivate for next week, "If I asked your teacher, Mr./Ms _____ what signs of success he or she noticed, what do you think he or she would say?"
- Homework to include *writing down* signs of success.

Session 5: Elicit, Amplify, and Reinforce Change

- Follow up on homework, looking for opportunities to elicit descriptions of success, amplify change, and reinforce new behaviors; use exception questions.
- Homework and tasks to continue moving up the scale.

Session 6: Older, Wiser Self

- Follow up on progress with scaling question.
- Instruct students to write a letter to themselves from their older, wiser self (Dolan, 1995): "Imagine that you have grown to be a healthy, wise old man or woman and you are looking back on this period of your life. What would this older and wiser person suggest to you to help you reach your goals?"

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Session 7: New Self

- Review letters from older, wiser self.
- Discuss how "new self" is starting to emerge and how others are responding to it.

Session 8: Prepare for Setbacks; Celebrate Success

- Discuss achievements using scaling questions.
- Normalize and create a plan for dealing with setbacks.
- Distribute certificates to celebrate success.

Working on What Works: Coaching Classrooms

Originally developed by Insoo Kim Berg and Lee Shilts when consulting in Florida in 2002, Working on What Works (WOWW; Kelly & Bluestone-Miller, 2009; Kelly et al., 2008) is a solution-focused technique that school counselors use to help teachers and their classrooms improve behaviorally and academically. Serving as more of a consultant or coach, the school counselor uses strengths assessment and scaling to help teachers and students wok together to improve classroom performance and culture. Preliminary pilot research is promising, with positive increases in teachers' perception of student behavior, teachers' view of themselves as effective classroom managers, and students' perception of themselves and their behavior.

The WOWW coaching process involves three phases:

Phase 1: Observation and compliments (weeks 1–3): In this phase, the school counselor introduces the process to the class: "I'm going to be visiting your room to watch for all the things the class does that are good and helpful. I will report back to you what I see" (Kelly & Bluestone-Miller, 2009, p. 65). The counselor visits for about an hour, the first 45 minutes spent observing and the last 15 minutes reporting back by complimenting behaviors of individual students and groups of students.

Phase 2: Create goals and rating (scaling) system (weeks 4–6): Using a variation on scaling questions, the school counselor begins by having the class identify in *positive*, *behavioral* terms what the "best class" would be doing (e.g., raising their hands to speak, doing class work quietly, speaking kindly to each other). The counselor is careful that all descriptions of the best class are in terms of what the class *is doing*, not what they are not doing. Over one or more weeks, the counselor and class develop a rubric using a 1–5, 1–10, or smiley-face scale that the class will use for self-assessment, defining behaviors for each possible score.

Phase 3: Goal setting and amplifying change (remaining sessions): After the students have developed their goals and scale, the counselor coaches them on selecting one or two (no more) goals that the class is going to work on for the following week. The teachers are encouraged to scale progress *daily* and to do so on a chart that is always readily visible. The counselor's role is to notice and amplify strengths with each visit. Once one set of goals has been reached, new goals are set for the class to work toward.

Tapestry Weaving: Working with Diverse Populations

Ethnic, Racial, and Cultural Diversity

Because it does not use a theory of health to predefine client goals (O'Hanlon & Weiner-Davis, 1989), solution-focused therapy can be adapted to a wide range of populations and value systems. This therapy is widely used with diverse populations in North America, South America, Europe, the Middle East, Asia, and Australia (Gingerich & Patterson, 2007). It has also been studied with a range of clients, including immigrants, African Americans, Hispanics, Saudi Arabians, Chinese, and Koreans, and in a wide range of contexts, such as schools, prisons, hospitals, businesses, and colleges (Gingerich & Patterson, 2007). When working with diverse clients, solution-focused therapists access their unique emotional, cognitive, and social resources, which often relate to issues of diversity.

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Corcoran (2000) identifies several reasons why solution-focused therapy is generally a good fit for diverse populations:

- *Behavior considered in context:* The solution-based viewing of behaviors in context allows for a more fair understanding of problem behaviors of marginalized populations.
- *Client-generated, behavioral goals:* The goal-setting process of solution-based therapies is a good fit for many ethnic groups because the goals are set in the client's language, they are concrete and behavioral, and they are generally short-term.
- *Behavioral rather than emotional focus:* The focus on behavior rather than emotion is more comfortable and value-consistent for many ethnic minority groups.
- *Future orientation:* The focus on solving problems in the future rather than understanding the past makes sense to many ethnic minorities.

Asian Americans Several therapists have explored using solution-based therapies with Asians and Asian Americans. Hsu and Wang (2011) describe solution-focused therapy as being highly compatible for Asian clients because of its positive reframing (avoids losing face), relation-based perspective, and its focus on pragmatic solutions. Considerations for working with Asian clients include:

- *Filial piety:* Several therapists have used solution-focused therapy to help clients navigate issues of filial piety, a common Asian value in which elders are obeyed and honored (Lee & Mjelde-Mossey, 2004; Hsu & Wang, 2011). Solution-focused approaches help reframe each generation's perspective in positive terms, so the good intentions of each are better understood.
- *Form and content:* Many Asian societies value the *form—how* something is done—as much as the *content—what* is done (Berg & Jaya, 1993). This can translate to family members being more concerned about how someone approached a problem than what was done to solve it.
- *Practical solutions:* Asian cultures generally discourage dramatic displays of emotion, and this often translates to a preference for therapeutic approaches that focus on pragmatic solutions rather than exploration of feelings and causes (Berg & Jaya, 1993).
- *Saving face:* Solution-focused therapy is unique in that its focus on "what to do from here" rather than on identifying root causes more easily allows for Asian clients to save face. Asian cultures are *shame*-—not guilt-—based, and thus positive reframes and compliments work particularly well with these populations (Berg & Jaya, 1993).
- *Brief treatment:* As therapy is usually a last resort for Asian families who prefer privacy, the brief approach of solution-focused therapy is an excellent fit (Berg & Jaya, 1993).

Middle Eastern and South Asian and Muslim Americans Chaudhry and Li (2011) have identified solution-focused counseling as a theoretical approach that can be culturally sensitive and appropriate for working with Middle Eastern and South Asian and Muslim Americans. They believe that the general approach of having a future focus, concrete goals, and limited self-disclosure is a good cultural fit. In addition, Muslim Americans typically have strong family and community ties, resources that solution-focused counselors are typically quick to acknowledge and utilize. Furthermore, as Middle Eastern and South Asian Muslim Americans tend to first seek support through family, community, and their religious clergy, they tend to seek professional counseling for only specific problems; thus, the "don't fix what isn't broken" philosophy of solution-focused counseling will respect this cultural boundary.

Specifically, Chaudhry and Li (2011) cite the following elements of solution-focused counseling as particularly applicable for working with Middle Eastern and South Asian Muslim Americans:

- *Problem-Free Talk:* Problem-free talk allows for a greater sense of privacy and reduces a sense of shame, which is important for Muslim Americans who have encountered a significant increase in discrimination in past decades in the United States.

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- *Pre-Session Change:* Identifying pre-session change similarly reduces embarrassment and can honor and acknowledge resources in the client's existing family and community.
- *Goal Setting:* The positive framework for goal setting in solution-focused counseling, combined with the focus on client goals rather than counselor-defined goals, can help Muslim American clients become engaged and trusting of the counseling process.
- *Competence Seeking:* By taking time to identify competence, the counselor has an opportunity to acknowledge numerous culture-based strengths and resources, conveying a sincere sense of respect and understanding of the client's culture.
- *Miracle Question:* Using the miracle question early in the process can improve engagement of Muslim Americans by creating a clear vision and purpose for the counseling process and enhancing clients' sense of safety, because hopeful, uplifting emotions are invoked.

Sexual Identity Diversity

Because it does not have a predefined theory of health and focuses on client-defined goals, solution-based therapies can be appropriate when working with gay, lesbian, bisexual or transgendered clients. However, to be sensitive to these issues, therapists should inquire with "beginner's mind" about their possible role in the client's presenting problem rather than assume that because it is not mentioned it is not part of the problem or solution. Little has been written specifically on solution-based therapies and these populations. However, this approach has been used to facilitate adjustment to one's spouse coming out. Treyger, Ehlers, Zajicek, and Trepper (2008) found solution-based therapy appropriate for a case in which a woman's spouse announced he was gay. The approach was used to help the client identify her own solutions to the situation in a supportive, nonpathologizing context. They used Buxton's (2004) seven-stage model for partner adjustment to news that their spouse is homosexual or bisexual; the stages include: disorientation/disbelief, facing and acknowledging reality, accepting, letting go, healing, reconfiguring and refocusing, and transforming. The client in Treyger et al. (2008) reported that what helped the most from the approach was talking without being judged, not being given advice (which her family and friends offered plenty of), positive feedback and compliments, and scaling questions to concretely measure progress.

Research and the Evidence Base

Solution-based therapies have a steadily growing foundation of empirical support. Two recent meta-analyses of well-controlled, clinical trial studies (Stams, Dekovic, Buist, & De Vries, 2006; Kim, 2008) found that the solution-focused brief therapy has modest effect sizes and typically has equivalent outcomes to other approaches but typically does so in less time and therefore at less cost (Gingerich, Kim, Stams, & MacDonald, 2012). As further evidence of its growing evidence base, the Office of Juvenile Justice and Delinquency Prevention has recognized it as a promising practice, setting the stage for recognition as an evidence-based practice (Kim, Smock, Trepper, McCollum, & Franklin, 2010).

The majority of research has been conducted on solution-focused brief therapy, which was first described in the literature in 1986, had its first controlled study in 1993, and has had a total of 48 published studies and two meta-analytic reviews (Gingerich et al., 2012). The quality of studies is steadily improving, including randomized samples, treatment fidelity measures, and standardized outcome measures. Researchers have studied the effectiveness of solution-focused brief therapy with a wide range of clinical populations and problems, including domestic violence offenders, couples, schizophrenics, child abuse, troubled youth, school settings, parenting, alcohol, and foster care (Franklin, Trepper, Gingerich, & McCollum, 2012). Research on the process of solution-focused brief therapy suggests that presuppositional questions, the miracle question, the first-session task, scaling questions, and solution talk have been found to

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accomplish their intended therapeutic effect and that the model in general engenders hope and optimism in clients (McKeel, 2012).

Currently, quantitative research in solution-focused brief therapy has focused on refining and improving clinical trial studies through the expansion of a standardized treatment manual (Trepper et al., 2012) and development of improved adherence and fidelity measures (Lehman & Patton, 2012). In addition, process research is being done on in-session therapeutic alliance and client progress as both an outcome measure and collaborative intervention (Duncan, Miller, & Sparks, 2004; Gillaspy & Murphy, 2012). Finally, of particular interest in psychotherapy research is the examination of the mechanisms of change, which underlie an evidenced-based clinical approach such as solution-focused brief therapy. Laboratory experiments have provided evidence for some of the major underlying theoretical assumptions of solution-focused brief therapy; for example, that collaboration and co-construction led to significantly better outcomes in the laboratory (Bavelas, 2012). Also, microanalysis research has shown that solution-focused therapists are overwhelmingly positive in their formulations and questions as compared with client-centered and cognitive-behavioral therapists, whose formulations and questions were primarily negative (Tomori & Bavelas, 2007; Korman et al., 2012; Smock et al., 2012). It was also shown that this "positive talk" led to more positive talk, and negative talk led to more negative talk (Smock et al., 2012). Thus "… a therapist's use of positive content seems to contribute to the co-construction of an overall positive session, whereas negative content would do the reverse" (Bavelas, 2012, p. 159). This area of research may someday refine understanding of the exact mechanisms of change of solution-focused brief therapy and how this approach differs from other clinical models.

Solution-Focused Case Study

Marcella, a 32-year-old nurse practitioner, is seeking treatment after her brother was killed in a car accident. On the one hand, she is saddened by his tragic death, but on the other, she feels a smug sense of vindication because she feels that God has finally punished him for sexually abusing her when she was 12. She has been feeling depressed since his death, partially because of the grief and partially because his death has brought up memories of the abuse for which she never sought treatment (because, although her parents intervened to stop her brother when she finally told, they never sought outside assistance to avoid shaming the family). Her parents, who immigrated from the Philippines to the states when they were young, encouraged her to forgive him and to pray to Mother Mary when she needed comfort. However, during that time, she cut herself to cope with the pain and has started doing so again. After coming out in college, Marcella has not been close to her parents or family, who are strict Catholics. Marcella's partner has been very supportive of her but increasingly bitter toward Marcella's family, whom she sees as not supporting Marcella like they should have. Marcella says that the loss of her brother makes her want to be closer to her family, which has been more connected since the death, and to regain the self-confidence she feels she lost after the abuse. Her long-term goal is to be a pediatrician, but she has never felt she was good enough to be a doctor. Marcella finds her greatest peace when horseback riding, a hobby she has had since childhood.

Case Conceptualization: Solution-Focused

Strengths

AF was brave and confident enough to come out to her family, who she knew would not be supportive of her. She was raised with strong religious faith, which she still possesses and is using to help make sense of her brother's death and her healing from the abuse. She has been professionally successful and has clear goals for her next career move. Although she cuts, she does not report suicidal thoughts; explore these strengths further with her.

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Exceptions, Previous Solutions, and "What Works"

AF feels most at peace while horseback riding, which provides periods when she does not feel overwhelmed by her brother's death or memories of the abuse. She also describes a supportive partner and some regular connection with her family since the death, thus lessening the distance that had been created when she came out. Identify the times when she could cut but does not.

The Miracle Question

AF's miracle involves having a good relationship with her family, who accepts her as she is, which says would involve having regular dinners and celebrating holidays together. She also describes herself as pursuing her dream to become a pediatrician, and talking to her partner or going horseback riding when she feels stressed and overwhelmed. Finally, she says she would be able to remember the abuse without being flooded with emotion and would be able to forgive her brother.

Client Motivation: Visitor, Complainant, and Customers

AF initially presents as a complainant, seeing the problem as her brother's death and abuse, but seems to be ready to be a customer for change, as evidenced by her goals to want a closer connection to her family, feel confident again, and pursue advanced career goals.

Solution-Focused Description of Problem/Solution

Since the death of her brother a few months ago, AF has been experiencing memories of her abuse and coping by cutting, a habit she stopped years ago and is intent on stopping again. She wants to regain a sense of peace with herself, which she says would take the form of having the confidence to pursue her dream career, and to make peace with her family, which she says would take the form of regular visits for holidays and Sunday dinners. She has a supportive partner and strong sense of faith to support her through this period of healing and personal growth.

Treatment Plan: Solution-Focused

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration:* Ensure that AF feels that her sexual orientation and ethnicity are respected in the counseling relationship; respect and engage her religious faith and strengths.
   Relationship building intervention:
   a. Build rapport by identifying **strengths** and **resources** and **channeling language to delimit problem**, identify areas of **functioning despite the abuse**, and generate hope for full recovery.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Consider immigration history and Filipino Catholic family norms when assessing family and larger cultural systems.
   Assessment Strategies:
   a. **Miracle question** to obtain behavioral description of solutions and motivate AF to make specific changes; ask question to emphasize what will be different in relation to the problem and what she will be doing differently.
   b. **Identify exceptions**, **previous solutions**, "**what works**," **pre-session change**, and **strengths**.

Initial Phase Client Goals

1. *Increase* safety and ability to **use resources** when feeling overwhelmed by emotions to stop cutting.

(*continued*)

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Interventions:

a. Motivate client to use **scaling for safety** to generate **step-by-step safety plan**; involve partner if possible.
b. Identify personal, relational, and community **resources** to provide immediate support for client when feeling as though she wants to self-harm.
c. **Formula first session task** to identify what *is* working well right now and to generate hope between the first and second sessions.

Working Phase of Treatment

Working Phase Counseling Tasks

1. *Monitor quality of the working alliance. Diversity consideration:* Continue to ensure that AF feels safe in the counseling relationship and that her sexual orientation, ethnicity, and religious beliefs are respected.
   Assessment Intervention:
   a. Session Rating Scale; adjust alliance as she becomes more of a customer for change; if intervention does not work, **do something different**.

Working Phase Client Goals

1. *Increase* proactive behaviors that build sense of confidence to reduce depressed mood related to abuse.
   Interventions:
   a. **Scaling questions** to identify specific behavioral tasks that represent an increase in self-confidence each week to generate incremental improvement.
   b. **Coping questions** to help AF identify all the ways she has coped with the abuse and alienation from family because of her sexual orientation.
2. *Increase* satisfying contact with family of origin to reduce depressed mood.
   Interventions:
   a. **Scaling questions** to identify specific behavioral tasks each week that are likely to lead to improved relations with her family.
   b. **Videotalk** to identify specific behaviors she can use to improve relationship with family.
3. *Increase* ability to effectively manage strong emotions to reduce desire to cut and grief feelings.
   Interventions:
   a. **Scaling questions** to identify specific things she can do to (a) avoid emotions from becoming overwhelming and (b) effectively manage them as they first arise.
   b. **Presuppositional questions** to help client envision herself as able to handle strong emotions effectively.

Closing Phase of Treatment

Closing Phase Counseling Tasks

1. *Develop aftercare plan and maintain gains. Diversity consideration:* Consider supportive resources in gay, Catholic, and/or Filipino community.
   Intervention:
   a. Adapt **miracle question** to have AF envision future problems and how she can use resources learned in counseling to handle them.
   b. Involve partner in identifying early signs of relapse and return to cutting.

Closing Phase Client Goals

1. *Increase* confidence and solidify new **identity** as someone who has worked through sexual abuse and loss of brother to reduce depressed mood.

(*continued*)

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Interventions:

a. **Compliments and encouragement** to build confidence and identity as someone who has developed numerous resources and discovered great personal strength through her ordeals.
b. **Scaling questions** to reflect on progress and what worked; discuss how to maintain these gains in the years ahead.

2. *Increase* proactive behavior to reach professional goals (personal/relational dynamic) to reduce sense of hopelessness.
Interventions:
a. **Compliments and encouragement** to develop confidence and resolve to follow her life dreams.
b. **Scaling into the future** to anticipate ups and downs in pursuing MD and how to manage.

Questions for Personal Reflection and Class Discussion

1. What balance of focusing on the problem versus the solution makes most sense to you?
   - How might this vary depending on the presenting problem?
   - How might this vary depending on the client?
   - How might this vary depending on the client's culture of origin?
2. Are you the type of person who easily finds the silver lining in a given situation?
   - If so, how did you develop this skill?
   - If not, do you find your problem-focus helpful?
3. Write out the miracle question related to a current problem you are currently facing.
   - Was it difficult to imagine life without the problem?
   - Was it a challenge to describe "behaviors" that were different in positive terms?
4. Use a scaling question with a current problem. What are three small steps you can take during the next week to make small improvements?
5. What strengths does this approach have for working with diverse clients? What limitations?
6. What benefits does this approach have for working in a school context? What limitations?

Online Resources

Associations

Milton H. Erickson Foundation
www.erickson-foundation.org

Solution-Focused Brief Therapy Association
www.sfbta.org

Solution-Oriented, Possibility Therapy
www.billohanlon.com

Divorce Busting
www.divorcebusting.com

European Brief Therapy Association
www.ebta.nu

Review of Solution-Focused Therapy Research
http://gingerich.net/SFBT/2007_review.htm

Videos

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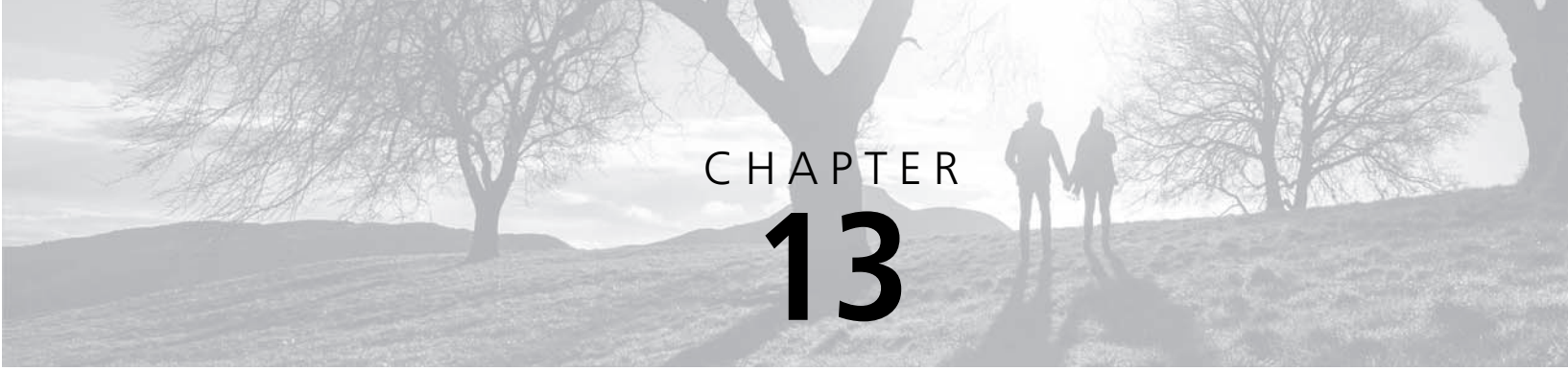

CHAPTER

13

Narrative and Collaborative Approaches

Lay of the Land

If you thought that systemic ideas were challenging to how we normally perceive the world (i.e., I am totally separate from you), the postmodernists really shake things up, calling into question unquestionable assumptions, such as the self, coherent identity, and independent thought. The newest kids on the block, postmodern counseling approaches are grounded in social constructionist theories that examine how societal discourses (e.g., "talk of the town," media images, movie plots, and so on) about gender, culture, race, religion, and economic status affect a person's sense of personhood and the development of problems. Much like systemic approaches, these theories place an emphasis on interpersonal relationships and how they shape a person's understanding and experience of self. In fact, they radically posit that one's sense of self is constructed in and through relationships rather than being independently thought up in one's head. These approaches can be broadly divided into two streams of practice:

- *Narrative counseling:* Based on the work of Australia- and New Zealand-based practitioners Michael White and David Epston (1990), narrative counselors help separate people from their problems by exploring the sociocultural influences and language habits that maintain problems.
- *Collaborative approaches:* Developed by Harlene Anderson and Harry Goolishian (1988, 1992) in Texas and Tom Andersen in Norway (1991), collaborative approaches focus on facilitating dialogical conversations that "dissolve" problems with conversations and relationships that allow for the co-creation of new meaning related to problems.

Similar to solution-based counselors (see Chapter 12), postmodernists optimistically focus on client strengths and abilities. Despite many philosophical similarities, these approaches differ in significant ways, most notably their philosophical foundations, the stance of the counselor, the role of interventions, and the emphasis on political issues.

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	Narrative	Collaborative
Primary philosophical foundations	Foucault's philosophical writings; critical theory; social constructionism	Postmodernism, social constructionism; hermeneutics (the study of interpretation)
Counseling relationship	Active role as "coeditor" or "coauthor"	Facilitative role; democratic; "client is the expert"
Counseling process	Uses structured interventions; focus on various forms oppression	Avoids formal interventions; counselor focuses on facilitating dialogical process
Politics and social justice	Social justice issues regularly included in counseling conversations	Political issues raised tentatively for client consideration

Narrative Approaches

In a Nutshell: The Least You Need to Know

Developed by Michael White and David Epston in Australia and New Zealand, narrative counseling is based on the premise that we "story" and create meaning of life events using available *dominant discourses*—broad societal stories, sociocultural practices, assumptions, and expectations about how we should live. People experience "problems" when their personal lives do not fit with these dominant societal discourses and expectations. The process of narrative counseling involves *separating the person from their problem* by critically examining the assumptions that inform how the person evaluates himself or herself and his or her life. Through this process, clients identify alternative ways to view, act, and interact in daily life. Narrative counselors assume that all people are resourceful and have strengths, and they do not see "people" as having problems but rather see people as being imposed on by unhelpful or harmful societal cultural practices.

The Juice: Significant Contributions to the Field

If you remember one thing from this chapter, it should be …

Understanding Oppression: Dominant versus Local Discourses

Like feminist approaches, narrative counseling is one of the few theories that integrates societal and cultural issues into its core conceptualization of how problems form and are resolved. Narrative counselors maintain that problems do not exist separate from their sociocultural contexts, which are broadly constituted in what philosopher Michel Foucault referred to as *dominant discourses* (Foucault, 1980; White & Epston, 1990). *Dominant discourses* are culturally generated stories about how life should go that are used to coordinate social behavior, such as how married people should act, what happiness looks like, and how to be successful. These dominant discourses organize social groups at all levels: large cultural groups down to an individual couple and family, stories about how life should go. These discourses are described as *dominant* because they are foundational to how each of us behaves and evaluates our lives, yet we are rarely conscious of their impact or origins.

Foucault contrasts *dominant discourses* with *local discourses*, which occur in our heads, our closer relationships, and marginalized (not mainstream) communities. Local discourses have different "goods" and "shoulds" than dominant discourses. A classic example is women's valuing of relationship compared to men's valuing of outcome in typical work environments. Both discourses have a value they are working toward; however, men's is generally privileged over women's and thus is considered a dominant discourse, while women's is local. Narrative counselors closely attend to the fluid interactions of

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local and dominant discourses and how these different stories of what is "good" and valued collide in our web of social relationships, creating problems and difficulties. By attending to this level of social interaction, narrative counselors help clients become aware of how these different discourses are impacting their lives; this awareness serves to increase clients' sense of agency in their struggles, allowing them to find ways to more successfully resolve their issues.

Rumor Has It: The People and Their Stories

Michael White A pioneer in narrative counseling and the first to write about the process of *externalizing* problems, Michael White was based at the Dulwich Centre in Adelaide, Australia. Along with David Epston, he wrote the first book on narrative counseling, *Narrative Means to Therapeutic Ends* (White & Epston, 1990). His last publication, *Maps to Narrative Practice* (White, 2007), describes his later work before his death in 2008.

David Epston From Auckland, New Zealand, David Epston worked closely with Michael White in developing the foundational framework for narrative counseling. His work emphasized creating unique sources of support for clients, such as writing letters to clients to solidify the emerging narratives and developing communities of concern or *leagues* (see section "Leagues") in which clients provide support to each other.

Jill Freedman and Gene Combs Based in the United States, husband-and-wife team Jill Freedman and Gene Combs (1996) have developed the narrative approach emphasizing the process of the social construction of realities and further developed the narrative metaphor for conceptualizing counseling intervention. They are the codirectors of the Evanston Family Therapy Center in Evanston, Illinois.

Gerald Monk and John Winslade Beginning their work in New Zealand and now working in the United States, Gerald Monk and John Winslade have developed narrative approaches for school counseling, multicultural counseling, mediation, and consultation (Monk, Winslade, Crocket, & Epston, 1997; Monk, Winslade, & Sinclair, 2008; Winslade & Monk, 2000, 2007, 2009).

Big Picture: Overview of Counseling Process

The process of narrative counseling involves helping clients find new ways to view, interact with, and respond to problems in their lives by redefining the role of problems in their lives (White, 2007). From a narrative perspective, "persons are not the problem; problems are the problem." Although there is variety among practitioners, narrative counseling broadly involves the following phases (Freedman & Combs, 1996; White & Epson, 1990):

- *Meeting the person:* Getting to know people separate from their problems by learning about hobbies, values, and everyday aspects of their lives
- *Listening:* Listening for the effects of dominant discourses and identifying times without the problems
- *Separating persons from problems:* Externalizing and separating people from their problems to create space for new identities and life stories to emerge
- *Enacting preferred narratives:* Identifying new ways to relate to problems that reduce their negative effects on the lives of all involved and to "thicken" their identity and problem stories (see section "Thickening Descriptions")
- *Solidifying:* Strengthening preferred stories and identities by having them witnessed by significant others in a person's life

Thickening Descriptions

Narrative counseling process is a *thickening* and enriching of the person's identity and life accounts rather than a "story-ectomy," the replacing of a problem story with a problem-free one. Instead, narrative counselors *add* new strands of identity to the problem-saturated descriptions with which clients enter counseling. In a given day, there

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are an infinite number of events that can be storied into our accounts of the day and who we are. When people begin to experience problems, they tend to notice *only* those events that fit with the problem narrative. For example, if a person is feeling hopeless, he or she tends to notice when things do not go his or her way during the day and does not give much weight to the good things that happened. Similarly, when couples start a period of fighting, they start to notice only what the other person is doing that confirms their position in the fight and ignore and/or forget other events. In narrative counseling, the counselor helps clients create more *balanced* descriptions of the events of their lives to enable clients to build more accurate and appreciative descriptions of themselves and others, helping clients build successful and enjoyable lives.

Making Connection: Counseling Relationship

Meeting the Person Apart from the Problem

Narrative counselors generally begin their first session with clients by *meeting the person apart from the problem*: meeting clients as everyday people before learning about the problem (Freedman & Combs, 1996). When meeting a client apart from the problem, narrative counselors ask questions such as the following to familiarize themselves with clients' everyday lives:

Questions for Meeting the Person Apart from the Problem

- What do you do for fun? Do you have hobbies?
- What do you like about living here? What don't you like?
- Tell me about your friends and family.
- What is important to you in life?
- What is a typical weekday like? Weekend?

The answers to these questions enable narrative counselors to know and view their clients much in the same way that clients view themselves: as an everyday person. This brief and seemingly mundane intervention can have profound effects in terms of developing an effective counseling relationship and informing meaningful interventions. In the case study at the end of this chapter, the counselor makes a concerted effort to meet Elan apart from his role in the death of his friend and his alcohol use, both of which have strong, negative social stereotypes, thus helping Elan to feel accepted and valued as a person from the beginning of their relationship.

Separating People from Problems: The Problem Is the Problem

In narrative counseling, the motto is, "The problem is the problem. The person is not the problem" (Winslade & Monk, 1999, p. 2). Once counselors have gotten to know the client apart from the problem and have a clear sense of who the client is as a person, they begin to "meet" the problem in much the same way, keeping their identities separate. The problem—whether depression, anxiety, marital conflict, attention-deficit/ hyperactivity disorder, defiance, loneliness, or a breakup—is viewed as a separate entity or situation that is *not* inherent to the person of the client. The attitude is again one of a polite, social "getting-to-know-you" feel.

Questions for "Meeting" the Problem

- When did the problem first enter your life?
- What was going on with you then?
- What were your first impressions of the problem? How have they changed?
- How has your relationship with the problem evolved over time?
- Who else has been affected by the problem?

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Narrative counselors can take an adversarial stance (wanting to outwit, outsmart, or evict the problem; White, 2007) or a more compassionate stance toward the problem (wanting to understand its message and concerns; Gehart & McCollum, 2007).

Optimism and Hope

Because narrative counselors view problems as problems and people as people, they have a deep, abiding optimism and hope for their clients (Monk et al., 1997; Winslade & Monk, 1999). Their hope and optimism are not a sugarcoated, naive wish but instead are derived from their understanding of how problems are formed—through language, relationship, and social discourse—and having confidence that their approach can make a difference. Furthermore, by separating people from their problems, they quickly connect with the "best" in the client, reinforcing a sense of hope and optimism.

Coauthor/Coeditor

The role of the counselor is often described as a *coauthor* or *coeditor*, emphasizing that the counselor and client engage in a joint process of constructing meaning (Freedman & Combs, 1996; Monk et al., 1997; White & Epston, 1990). Rather than attempting to offer a "better story," the counselor works alongside the client to generate a more useful narrative. The degree and quality of input on the part of the counselor vary greatly among narrative counselors, and there is a tendency to focus on the sociopolitical aspects of a client's life. In fact, some narrative counselors maintain that counselors should take a stance on broader sociocultural issues of injustice with all clients (Zimmerman & Dickerson, 1996), although this agenda is not shared by all narrative counselors (Monk & Gehart, 2004).

Investigative Reporter

In his later works, White (2007) describes his relationship to problems as that of an *investigative reporter*:

> The form of inquiry that is employed during externalizing conversations can be likened to investigative reporting. The primary goal of investigative reporting is to develop an expose on the corruption associated with abuse of power and privilege. Although investigative reporters are not politically neutral, the activities of their inquiry do not take them into the domains of problem-solving, of enacting reform, or of engaging indirect power struggles … their actions usually reflect a relatively "cool" engagement. (pp. 27–28)

Thus, the counselor uses a calm but inquisitive stance when exploring the origins of problems with clients, to inspire the clients to develop a better understanding of the larger context of the problem rather than rushing in to fix it.

The Viewing: Case Conceptualization

Problem-Saturated Stories

As clients are talking, narrative counselors listen for the *problem-saturated story* (Freedman & Combs, 1996; White & Epston, 1990), the story in which the "problem" plays the leading role and the client plays a secondary role, generally that of victim. The counselor attends to the ways the problem affects the client at an *individual level* (health, emotions, thoughts, beliefs, identity, relationship with the divine, and so on) and how it affects him or her at a *relational level* (significant other, parents, friends, coworkers, teachers, and such) as well as how it affects each of these significant others at a personal level. While listening to a client's problem-saturated story, the counselor listens closely for alternative endings and subplots in which the problem is less of a problem and the person is an effective agent in the story; these are referred to as *unique outcomes*.

Unique Outcomes and Sparkling Events

Unique outcomes (White & Epston, 1990) or *sparkling events* (Freedman & Combs, 1996) refer to stories or subplots in which the problem-saturated story does not play

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out in its typical way: the child cheerfully complies with a parent's request, a couple is able to stop a potential argument from erupting with a soft touch, or a teenager decides to call a friend rather than allow herself to cut. These stories often go unnoticed because they had no dramatic ending or particularly notable outcome that warrants attention, and therefore they are not "storied" in clients' or others' minds. These unique outcomes are used to help clients create the lives they prefer and to develop a more full and accurate account of their and others' identities.

Dominant Cultural and Gender Discourses (see "The Juice")

Narrative counselors listen for dominant cultural and gender themes that have informed the development and perception of a problem (Monk et al., 1997; White & Epston, 1990). The purpose of all discourses is to identify the set of "goods" and "values" that organize social interaction in a particular culture. All cultures are essentially a set of dominant discourses: social rules and values that make it possible for a group of people to meaningfully interact.

Dominant discourses are the societal stories of how life "should" go: for example, to be a "happy" and "good" person, you should get married; get a stable, high-paying job; have kids; get a nice car; buy a house; volunteer at your child's school; and build a white-picket fence. Whether you comply with this vision of happiness, rebel against it, or simply are not even in the game because of social or physical limitations that prevent it, problems can arise in relation to it. In working with clients, narrative counselors listen closely for the dominant discourses that are most directly informing the perception of a problem. In response, they inquire about *local* or *alternative discourses*.

Local and Alternative Discourses: Attending to Client Language and Meaning

Local and *alternative discourses* are those that do not conform to the dominant discourse (White & Epston, 1990): couples who choose not to have children, same-sex relationships, immigrant families wanting to preserve their roots, speaking English as a second language, teen subculture in any society, and so on. The local discourses offer a set of "goods," "shoulds," and ethical "values" that are different from what is portrayed in the dominant discourse. If we take the case of teens and adults in the same culture, the teens have created a subculture with a different set of "goods," beauty standards, sexual norms, vocabulary, friendship rules, and so on. The teen culture represents an alternative discourse that counselors can tap into to understand the teen's worldview and values and also explore with the teen how this alternative discourse can successfully coexist with the dominant discourse. Thus, the local discourse provides a resource for generating new ways of viewing the self and talking and interacting with others around the problem.

Targeting Change: Goal Setting

Preferred Narratives and Identities

As a postmodern approach, narrative counseling does not include a set of predefined goals that can be used with all clients. Instead, goal setting in narrative counseling is unique to each client. In the broadest sense, the goal of narrative counseling is to help clients enact their *preferred narratives and identities* (Freedman & Combs, 1996). In most cases, enacting preferred narratives and identities involves increasing clients' sense of *agency*, the sense that they influence the direction of their lives. When identifying these preferred realities, counselors work with clients to develop thoughtfully reflected goals that consider local knowledges rather than simply adopting the values of the dominant culture. During the process of counseling, clients often redefine their preferred narrative to incorporate local knowledges and lessen the influence of dominant discourses. For example, many gay men find that they prefer the gay subculture in one city more than another, highlighting that even within local cultures, there can be multiple variations of local knowledges that a person can choose to connect with. Thus, the key is

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defining the "preferred" narrative and identity thoughtfully and with intention after considering the impact of dominant and local discourses. This process is often a gradual shift from "make this problem go away" to "I want to create something beautiful/meaningful/great with my/our life/lives."

Examples of Working Phase: Targeting Immediate Symptoms and Presenting Problem

- Reduce frequency of allowing depression to talk client into avoiding pleasurable activities.
- Increase opportunities to interact with friends using "confident, social" self.
- Increase instances of defiance in response to anorexia's directions to not eat.

Examples of Closing Phase: Targeting Personal Identity, Relational Identity, and Expanded Community

- *Personal identity:* Solidify a sense of personal identity that derives self-worth from meaningful activities, relationship, and values rather than body size.
- *Relational identity:* Develop a family identity narrative that allows for greater expression of differences while maintaining family's sense of closeness and loyalty.
- *Expanded community:* Expand preferred "outgoing" identity to social relationships and contexts.

The Doing: Interventions

Externalizing: Separating the Problem from the Person

The signature technique of narrative counseling, *externalizing* involves conceptually and linguistically separating the person from the problem (Freedman & Combs, 1996; White & Epston, 1990). To be successful, externalization requires a sincere belief that people are separate from their problems; thus, the *attitude* of externalization is key to its effectiveness (Freedman & Combs, 1996). More than a single-session intervention, externalization is an organic and evolving process of shifting the client's perception of their relationship to the problem from "having" it to seeing it outside the self. Counselors can externalize by naming the problem as an external other, switching a descriptive adjective into a noun, such as from a client being depressed to having a relationship with depression. Other times, clients respond better talking about "sides" of themselves or a relationship, such as "the little girl in me who is afraid" or "the competitive side of our relationship."

For externalization to work, it cannot be forced onto the client; rather, it needs to emerge from the dialogue or be introduced as a possibility for how to think about the situation. In most cases, using techniques such as *mapping the influence of persons and problem* (see below) invites a natural, comfortable process for externalizing the problem. Periodically, clients already have a name for the problem and conceptualize the problem as a sort of external entity or very discrete part of themselves, and in such cases counselors need only to build on the externalization process the client has started.

Relative Influence Questioning: Mapping the Influence of the Problem and Persons

Relative influence questioning was the first detailed method for externalization (White & Epston, 1990). Used early in counseling, relative influence questioning serves as an assessment and intervention simultaneously and is composed of two parts: (a) mapping the influence of the problem and (b) **mapping the influence of persons**.

Mapping the Influence of Problems When mapping the influence of problems, counselors inquire about the ways the problem has affected the life of the client and significant others in the client's life, often *expanding* the reach of the problem beyond how the client generally thinks of it; thus, it is critical that this is followed up by *mapping the influence of person* questions to ensure that the client does not feel worse afterward.

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Mapping the influence of problems involves asking about how the problem has affected the following:

Mapping the Influence of the Problem

Examine all the ways the problem has affected the client.

- The client at a physical, emotional, and psychological level
- The client's identity story and what he or she tells oneself about his or her worth and who he or she is
- The client's closest relationships: partner, children, parents
- Other relationships in the client's life: friendships, social groups, work/school colleagues, and so on
- The health, identity, emotions, and other relationships of significant people in the client's life (e.g., how parents may pull away from friends because they are embarrassed about a child's problem)

Mapping the Influence of Persons Mapping the influence of persons begins the externalization process more explicitly. This phase of questioning, which should immediately follow *mapping the influence of problems*, involves identifying how the person has affected the life of the problem, reversing the logic of the first series of questions:

Mapping the Influence of Persons

Examine how the client has affected the problem.

- When have the persons involved kept the problem from affecting their mood or how they value themselves as people?
- When have the persons involved kept the problem from allowing them to enjoy special and/or casual relationships in their lives?
- When have the persons involved kept the problem from interrupting their work or school lives?
- When have the persons involved been able to keep the problem from taking over when it was starting?

Try It Yourself

Find a partner and take turns mapping the influence of the problem and the influence of persons related to a current life situation. How did the first set of questions affect you? How did the second set affect you?

White and Epston (1990) report the following benefits to externalization:

- Decreases unproductive conflict and blame between family members
- Undermines sense of failure in relation to the problem by highlighting times the persons have had influence over it
- Invites people to unite in a struggle against the problem and reduce its influence
- Identifies new opportunities for reducing the influence of the problem
- Encourages a lighter, less stressed approach to interacting with the problem
- Increases interactive dialogue rather than repetitive monologue about the problem

Externalizing Conversations: The Statement of Position Map

White (2007) describes his more recently developed process for facilitating externalizing conversations, *the statement of position map*. This map includes four categories of

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inquiry that are used multiple times throughout a session and across sessions to shift the client's relationship with the problem and open new possibilities for action:

Inquiry category 1: Negotiating a particular, experience-near definition of the problem: White begins by defining the problem using the client's language (experience-near) rather than professional or global terms (e.g., a diagnosis). Thus, "feeling blue" is preferred to "depressed."

Inquiry category 2: Mapping the effects of the problem: Similar to his early work (White and Epston, 1990), mapping the effects of problems involves identifying how the problem has affected the various domains of the client's life: home, work, school, and social contexts; relationships with family, friends, and oneself; and one's identity and future possibilities.

Inquiry category 3: Evaluating the effects of the problem's activities: After identifying the effects of the problem, the counselor asks the client to evaluate these effects (White, 2007, p. 44):

- Are these activities okay with you?
- How do you feel about these developments?
- Where do you stand on these outcomes?
- Is the development positive or negative—or both, or neither, or something in between?

Inquiry category 4: Justifying the evaluation: In the final phase, the counselor asks about how and why clients have evaluated the situation the way they did (White, 2007, p. 48):

- Why is/isn't this okay for you?
- Why do you feel this way about this development?
- Why are you taking this stand/position on this development?

These "why" questions must be offered in a spirit of allowing clients to give voice to what is important to them, rather than creating a sense of moral judgment. These questions should open up conversations about what is important to clients, what motivates them, and how they want to shape their identities and futures.

When externalizing using the four above categories, White (2007, p. 32) employs various metaphors for relating to problems:

- Walking out on the problem
- Going on strike against the problem
- Defying the problem's requirements
- Disempowering the problem
- Educating the problem
- Escaping the problem
- Recovering or reclaiming territory from the problem
- Refusing invitations from the problem
- Disproving the problem's claims
- Resigning from the problem's service
- Stealing their lives from the problem
- Taming the problem
- Harnessing the problem
- Undermining the problem

Avoid Totalizing and Dualistic Thinking

White (2007) avoids totalizing descriptions of the problem—the problem being all bad—because such descriptions promote dualistic, either/or thinking, which can be invalidating to the client and/or obscure the problem's broader context. In the case study at the end of this chapter, the counselor uses statement of position maps to enable Elan to clearly define a healthy and desired relationship to alcohol and the accident that killed his friend, rather than directly confront him on these issues.

Externalizing Questions

Narrative counselors use *externalizing questions* to help clients build different relationships with their problems (Freedman & Combs, 1996). In most cases, externalizing questions involve changing *adjectives* (e.g., depressed, anxious, angry, etc.) to *nouns* (e.g., Depression, Anxiety, Anger, etc.; capitalization is used to emphasize that the problem is viewed as a separate entity). Externalizing questions *presume* that the person is separate from the problem and that the person has a two-way relationship with the problem: it affects them, and they affect it.

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To experience the liberating effects of externalizing, Freedman and Combs (1996, pp. 49–50) have developed the following two sets of questions: one representing conventional counseling questions and the other externalizing. To do this exercise, choose a quality or trait that you or others find problematic, usually an adjective; substitute this for X in the following questions. Then find a noun form of that trait; substitute this for Y in the following questions. Examples include X = depressed/Y = Depression, X = critical/Y = Criticism, and X = angry/Y = Anger.

Conventional questions (Insert problem description as *adjective* for X)	*Externalizing questions* (Insert problem description as *noun* for Y)
When did you first become X?	What made you vulnerable to the Y so that it was able to dominate your life?
What are you most X about?	In what contexts is the Y most likely to take over?
What kinds of things happen that typically lead to your being X?	What kinds of things happened that typically lead to the Y taking over?
When you are X, what do you do that you wouldn't do if you weren't X?	What has the Y gotten you to do that is against your better judgment?
What are the consequences for your life and relationships of being X?	What effects does the Y have on your life and relationship?
How is your self-image different when you are X?	How has the Y lead you into the difficulties you are now experiencing?
If by some miracle you woke up some morning and were not X anymore, how, specifically, would your life be different?	Does the Y blind you from noticing your resources, or can you see them through it?
Are there times when you are not X?	Have there been times when you have been able to get the best of the Y? Times when the Y could have taken over, but you kept it out of the picture?

Problem Deconstruction: Deconstructive Listening and Questions

Based on the philosophical work of Jacques Derrida, narrative counselors use deconstructive listening and questions to help clients trace the effects of dominant discourses and to empower clients to make more conscious choices about which discourses they allow to affect their lives (Freedman & Combs, 1996). *Deconstructive listening* involves the counselor listening for "gaps" in clients' understanding and asking them to fill in the details or having them explain the ambiguities in their stories. For example, if a client reports feeling rejected because friends did not call when they said they would, the counselor would listen for the meanings that lead to the sense of feeling "rejected."

Deconstructive questions help clients to further "unpack" their stories to see how they have been constructed, identifying the influence of dominant and local discourses. Typically used in externalizing conversations, these questions target problematic beliefs, practices, feelings, and attitudes by asking clients to identify the following:

- The *history of their relationship* with the problematic belief, practice, feeling, or attitude ("When and where did you first encounter the problem?")
- *The contextual influences* on the problematic belief, practice, feeling, or attitude ("When is it most likely to be present?")
- *The effects or results* of the problematic belief, practice, feeling, or attitude ("What effects has this had on you and your relationship?")

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- *The interrelationship with other* beliefs, practices, feelings, or attitudes ("Are there other problems that feed this problem?")
- *Tactics and strategies* used by the problem belief, practice, feeling, or attitude ("How does it go about influencing you?")

Mapping in Landscapes of Action and Identity/Consciousness

Based on the narrative theory of Jerome Bruner (1986), "mapping the problem in the landscape of action and identity" (White, 2007) or "consciousness" (Freedman & Combs, 1996) refers to a specific technique for harnessing unique outcomes to promote desired change. Mapping in the landscapes of action and identity generally involves the following steps:

1. *Identify a unique outcome:* Listen for and ask about times when the problem could have been a problem but it was not.
2. *Ensure that the unique outcome is preferred:* Rather than assume, ask clients about whether the unique outcome is a preferred outcome: is this something you want to do or have happen more often?
3. *Map in landscape of action:* First, the counselor begins by mapping the unique outcome in the landscape of action, identifying what actions were taken by whom in which order. The counselor does this by asking specific details: What did you do first? How did the other person respond? What did you do next? The counselor carefully plots the events until there is a step-by-step picture of the actions of the client and others involved, gathering details about the following:
   - Critical events
   - Circumstances surrounding events
   - Sequence of events
   - Timing of events
   - Overall plot
4. *Mapping in the landscape of identity/consciousness:* After obtaining a clear picture of what happened during the unique outcome, the counselor begins a process of mapping in the landscape of identity. This phase of mapping *thickens the plot* associated with the successful outcome, thus directly strengthening the connection of the preferred outcome with the client's personal identity. Mapping in the landscape of identity focuses on the psychological and relational implications of the unique outcomes. Areas of impact include the following:
   - What do you believe this says about you as a person? About your relationship?
   - What were your intentions behind these actions?
   - What do you value most about your actions here?
   - What, if anything, did you learn or realize from this?
   - Does this change how you see life/God/your purpose/your life goals?
   - Does this affect how you see the problem?

Intentional versus Internal State Questions

White (2007) privileges *intentional* state questions (questions about a person's intentions in a given situation: "What were your intentions?") over *internal* state questions (questions about how a person was feeling or thinking: "What were you feeling?"), because intentional state questions promote a sense of *personal agency*, whereas internal state questions can have the effect of diminishing one's sense of agency, increasing one's sense of isolation, and discouraging diversity.

Scaffolding Conversations

White (2007) uses *scaffolding conversations* to move clients from that which is familiar to that which is novel, using developmental psychologist Vygotsky's concept of *zones of proximal development*. Vygotsky emphasized that learning is inherently relational, requiring adults to structure the child's learning in ways that make it possible for them to interact with new information. The "zone of proximal development" is the distance between what the child can do independently and what the child can do in collaboration

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with others. "Scaffolding" is a term that White developed to describe five incremental and progress movements across this zone of learning with clients:

- *Low-level distancing tasks: Characterizing a unique outcome:* Tasks that are at a low level of distance and very close to what is familiar to the client, encouraging the attribution of meanings to events that have gone unnoticed
- *Medium-level distancing tasks: Unique outcomes taken into a chain of association:* Tasks that introduce greater "newness," encouraging greater comparison and categorization of difference and similarity
- *Medium- to high-level distancing tasks: Reflection on chain of associations:* Tasks that encourage clients to reflect on, evaluate, and learn from the differences and similarities
- *High-level distancing tasks: Abstract learning and realizations:* Tasks that require clients to assume a high level of distance from their immediate experience, promoting increased abstract conceptualization of life and identity
- *Very high-level distancing tasks: Plans for action:* Tasks that promote a high-level distancing from immediate experience to enable clients to identify ways of enacting their newly developed concepts about life and identity

Over the course of a conversation, counselors move back and forth between various levels of distancing tasks, progressively moving to higher levels of action planning. In the case study at the end of this chapter, scaffolding questions are used to gently move Elan from noticing one exception of not drinking to developing concrete and motivating action plans for managing his drinking.

Permission Questions

Narrative counselors use permission questions to emphasize the democratic nature of the counseling relationship and to encourage clients to maintain a strong and clear sense of agency when talking with the counselor. Quite simply, permission questions are questions that counselors use to ask permission to ask a question. This goes against the prevailing assumptions that counselors can ask any question they want in order to gather information they purportedly need to be helpful to the client. Socially, counselors are exempt from the prevailing social norms of polite conversation topics and are free to bring up taboo subjects such as sex, past abuse, relationship problems, death, fears, and weaknesses. Many clients feel compelled to answer these questions even if they are not comfortable doing so. Narrative counselors are sensitive to the power dynamic related to taboo and difficult subjects and therefore *ask for the client's permission* before asking questions that are generally taboo or that the counselor anticipates will make this particular client feel uncomfortable. For example, "Would it be okay if I ask you some questions about your sex life?"

In addition, permission questions are used throughout the interview related to *what* is being discussed and *how* to ensure that the conversation is meaningful and comfortable for the client. For example, often when starting a session, the counselor may briefly outline his ideas for how to use the time, asking for client input and permission to continue with a particular topic or line of questioning. Similarly, in a situation when the counselor finds herself asking one person more questions than the others in a family session, she would pause to ask permission to continue to ensure that everyone was okay with what was going on.

Situating Comments

Similar to permission questions, *situating comments* are used to maintain a more democratic counseling relationship and reinforce client agency by ensuring that comments from the counselor are not taken as a "higher" or "more valid" truth than the client's (Zimmerman & Dickerson, 1996). Drawing on the distinction between dominant and local discourses, narrative counselors are keenly aware that any comment made by the counselor is often considered more "valid" than anything the client might say. Thus, counselors *situate* their comments by revealing the source of the perspective they are offering, emphasizing that it is only one perspective among others. By revealing the source and context of a comment, a client is less likely to overprivilege counselor comments.

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Counselor Comment Without Situating	Situating Counselor Comment
I am noticing that you tend to …	Having grown up on a farm, my attention is of course drawn to_____.
Research indicates that …	There is one counselor who has developed a theory/done a study that suggests … Does this sound like something that would be true for you?
I suggest that you _____.	Since you are asking me for a suggestion, I can only tell you what I think as someone who believes that action is more productive than talk.

Narrative Reflecting Team Practices

Based on Tom Andersen's collaborative practice of reflecting teams (see Tom Andersen below), narrative counselors have developed a similar practice that supports their work. Using Andersen's format, Freedman and Combs (1996) assign the team the *three primary tasks*:

1. Develop a thorough understanding by closely attending to details of the story.
2. Listen for differences and events that do not fit the dominant problem-saturated narrative.
3. Notice beliefs, ideas, or contexts that support the problem-saturated descriptions.

In addition, they propose the following *guidelines* for the team:

1. During the reflecting process, the reflecting team members participate together in a back-and-forth conversation rather than in a monologue.
2. Team members should not talk to each other while observing the interview.
3. Comments should be offered in a tentative manner (e.g., "perhaps," "could," "might," and such).
4. Comments are based on what actually occurs in the room (e.g., "At one point Mom got very quiet; I was wondering what was going on with her at that moment").
5. Comments are situated in the speaker's personal experience when appropriate (e.g., "Having been a teacher, I may have been the only one who focused on this …").
6. All family members should be responded to in some way.
7. Reflections should be kept short.

Leagues

As a means of solidifying the new narrative and identities, narrative counselors have created *leagues* (or clubs, associations, teams, etc.), membership to which signifies an accomplishment in a particular area. In most cases, leagues are virtual communities of concern (e.g., giving a child a membership certificate to the Temper Tamer's Club), although some meet face to face or interact via the Internet (Anti-Anorexia/Anti-Bulima League; see www.narrativetherapy.com).

Letters and Certificates

Narrative letters are used to develop and solidify preferred narratives and identities (White & Epston, 1990). Counselors can write *letters* detailing a client's emerging story after sessions in lieu of doing case notes (unless you work in a practice environment that requires a specific format). Narrative letters use the same techniques used in session to reinforce the emerging narrative and are characterized by the following:

- *Emphasizing client agency:* Highlighting client agency in their lives, including small steps in becoming proactive.

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- *Taking observer position:* The counselor clearly takes the role of *observing* the changes the client is making, citing specific, concrete examples whenever possible.
- *Highlighting temporality:* The time dimension is used to plot the emerging story: where clients began, where they are now, and where they are likely to go.
- *Encouraging polysemy:* Rather than propose singular interpretations, multiple meanings are entertained and encouraged.

Letters can be used early in counseling to engage clients, during counseling to reinforce the emerging narrative and reinforce new preferred behaviors, or at the end of counseling to consolidate gains by narrating the change process.

Sample Letter White and Epston (1990) offer numerous sample letters, such as the following:

Dear Rick and Harriet,

I'm sure that you are familiar with the fact that the best ideas have the habit of presenting themselves after the event. So it will come as no surprise to you that I often think of the most important questions after the end of an interview. Anyway, I thought I would share a couple of important questions that came to me after you left our last meeting: Rick, how did you decline Helen's [the daughter] invitation to you to do the reasoning for her? And how do you think this could have the effect of inviting her to reason with herself? Do you think this could help her to become more responsible? Harriet, how did you decline Helen's invitations to you to be dependable for her? And how do you think this could have the effect of inviting her to depend upon herself more? Do you think that this could have the effect of helping her to take better care of her life? What does this decreased vulnerability to Helen's invitations to have her life for her reflect in you both as people? By the way, what ideas occurred to you after our last meeting? M.W. (pp. 109–110)

Certificates

Certificates are used often with children to recognize the changes they have made and to reinforce their new "reputation" as a "temper tamer," "cooperative child," and so on.

Certified Temper Tamer

This is to certify that

_____

has proven himself as a skilled Tamer of Tempers,

having gone two months without temper problems at home or school

using the following taming techniques that he developed for himself:

1. Asking for help when confused

2. Taking three deep breaths when the scent of Temper appears

3. Using soft words to talk about anger and frustration

Date of award: _____

Witnessed by: _____ (counselor)

_____ (parents)

_____ (teacher)

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Putting It All Together: Narrative Treatment Plan Case Conceptualization and Treatment Plan Templates

Theory-Specific Case Conceptualization: Narrative

- *Meeting Person apart from the Problem:* Describe who the person/people are apart from the problem: hobbies, interests, career, etc.
- *Problem-Saturated Narrative:* Describe how the problem is affecting the persons involved at all levels:
  - Personal level: emotional, behavioral, identity narrative, etc.
  - Relational level: conflicts or distance in significant relationships
  - Broader life circumstances: work, school, hobbies, etc.
- *Unique Outcomes/Sparkling Events:* Describe:
  - Times, contexts, relationships, etc. when the problem is less of a problem or not a problem.
  - The effect of persons on the problem: what things do people do that make the problem less of a problem?
- *Dominant Discourses*
  - *Cultural, ethnic, SES, religious etc.*: How do key cultural discourses inform what is perceived as a problem and the possible solutions?
  - *Gender, sexual orientation, etc.*: How do the gender/sexual discourses inform what is perceived as a problem and the possible solutions?
  - *Contextual, family, community, school, and other social discourses*: How do other important discourses inform what is perceived as a problem and the possible solutions?
- *Local/Alternative Narratives*
  - Identity/Self-Narratives: How has the problem shaped each family member's identity?
- *Local or Preferred Discourses:* What is the client's preferred identity narrative and/or narrative about the problem? Are there local (alternative) discourses about the problem that are preferred?

Treatment Plan Template: Narrative

Use this treatment plan template for developing a plan for clients with depressive, anxious, or compulsive types of presenting problems. Depending on the specific client, presenting problem, and clinical context, the goals and interventions in this template may need to be modified only slightly or significantly; you are encouraged to significantly revise the plan as needed. For the plan to be useful, goals and techniques should be written to target specific beliefs, behaviors, and emotions that the client is experiencing. The more specific, the more useful it will be to you.

Treatment Plan

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration:* [Describe how you will specifically adapt your approach to be sensitive to client diversity when developing the counseling relationship; this may include respecting cultured and gendered norms for emotional expression.]

(*continued*)

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Relationship building intervention:
   a. Meet the **person apart from the problem** to generate **hope**.

2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Invite significant friends and family for assessment session(s).
   Assessment strategies:
   a. **Relative influence questioning** and **deconstructive questions** to identify effects of problem and effects of person, noting key **dominant** and **local discourses**.
   b. **Identify unique outcomes** and **sparkling moments** that do not conform to problem-saturated narrative.

Initial Phase Client Goals (One to Two Goals): Manage crisis issues and/or reduce most distressing symptoms

1. *Increase* the client's ability to **resist invitations** to engage in [crisis behavior] to reduce [crisis symptom(s)].
   Interventions:
   a. **Relative influence questioning** to identify how client is "enticed" to engage in crisis behavior and times when the client resists these invitations.
   b. **Statement of position map** to identify client's desired "position" in relation to crisis behaviors; identify strategies, persons, and contexts that support the desired position.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* [Describe how you monitor the client's ongoing sense of connection with counselor and how you will specifically adapt monitoring and/or relationship based on client age, gender, cultural, sexual orientation, socioeconomic status, etc.]
   Assessment Intervention:
   a. Use **situating comments** and **permission questions** to situate counselor as **coeditor/investigative reporter**; regularly check in with client about alliance; use Session Rating Scale.

Working Phase Client Goals

1. *Increase* client's sense of **separation from** and **agency in relation to [the problem]** to reduce [specific symptoms: depression, anxiety, etc.].
   Interventions:
   a. **Externalizing questions** to separate client's identity from problem-saturated story.
   b. **Statement of position map** and **relative influence questioning** to externalize problem.

2. *Increase* frequency of [specific behavior] that supports the client's **preferred reality** to reduce [specific symptoms: depression, anxiety, etc.].
   Interventions:
   a. **Mapping in the landscapes of action and consciousness** to identify specific behaviors that support change.
   b. **Scaffolding questions** to help client move toward a new relationship with the problem.

3. *Increase* frequency of [specific behavior] that supports the client's **preferred reality** to reduce [specific symptoms: depression, anxiety, etc.].

(*continued*)

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Interventions:

a. **Mapping in the landscapes of action and consciousness** to identify specific behaviors that support change.
b. **Scaffolding questions** to help client move toward a new relationship with the problem.

Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity consideration:* [Describe how you will access resources in the communities of which they are a part to support them after treatment ends. Involve significant others when possible.]
   Intervention:
   a. Use **mapping in the landscape of action and consciousness** questions to help clients identify how they can resist invitations from the presenting problem and similar problems in the future.

Closing Phase Client Goals

1. *Increase* and **thicken the plot** around the client's **new sense of identity** and **agency** in relation to the problem to reduce [specific symptoms: depression, anxiety, etc.].
   a. **Scaffolding questions** to develop action plans to bolster and sustain new identity.
   b. **Landscape of action and consciousness questions** to thicken new narratives that capture the outer and inner experience of client's preferred reality.
2. *Increase* **involvement of significant persons** in client's life to **witness and support new identity narrative** and new relationship to the problem to reduce [specific symptoms: depression, anxiety, etc.].
   Interventions:
   a. **Invite significant persons, leagues, and/or reflecting teams to session** to witness changes and identify ways to support client.
   b. **Certificates, letters, and other written documents** to solidify new identity and preferred narrative.

Collaborative Language Systems and Reflecting Teams

In a Nutshell: The Least You Need to Know

Putting postmodern, social constructionist principles into action, collaborative counseling is a two-way dialogical process in which counselors and clients coexplore and co-create new and more useful understandings related to client problems and agency. Eschewing scripted techniques, counselors focus on the *process* of counseling, namely, *how* what is of concern and importance to the client is explored and exchanged. As clients share their concerns, counselors listen for *how* the client interprets the events of their lives, responding by asking questions that naturally emerge from the conversation to better understand how the client's story "hangs together": the values and internal logic make the client's perspective make sense. As the counselor tries to understand the client *from within the client's worldview*, the client is naturally invited to share in the counselor's curiosity, joining in a process of shared inquiry—*mutual puzzling*—as to how things came to be and how things might best move forward. By asking questions and tentatively sharing their perspectives, and as counselor and client engage in the shared inquiry, alternative views on and future

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options for the client's situation emerge. This process of mutual exploring and wondering provides an opportunity for clients to see their situation differently, allowing them to make new interpretations and develop fresh ideas. The counselor does not try to control or direct the content of this meaning-making process; instead, they honor the client's agency in determining what to do with these new ideas.

I am guessing this process still sounds a bit vague, so perhaps it is best to offer an example. If a client says she is feeling "depressed," rather than hear concrete, diagnostic information, collaborative counselors are profoundly aware of how little they know about *this* client's unique experience of depression, thus becoming sincerely curious as to how the client came to this understanding of her experience. With no predetermined set of questions, the counselor asks questions that emerge from a genuine desire to better understand, such as: Does she cry often about something? About nothing? Has life gone to gray and nothing seems interesting anymore? Is her heart broken? Does she feel like a failure? There are as many unique depression stories as there are people who say they are depressed. As the counselor explores the client's view, asking questions such as the ones above, the client is invited to join in the curiosity about her depression. Each new understanding related to depression informs alternative actions, thoughts, and feelings, thus shifting experience on multiple levels until the client has found a way to manage or resolve her initial concern.

The Juice: Significant Contributions to the Field

If you remember one thing from this chapter, it should be …

Not Knowing and Knowing With

Goolishian and Anderson (1987) first introduced the idea of not knowing, perhaps one of the most frequently misunderstood concepts in the collaborative approach (Anderson, 2005), in 1988. At first blush, the *not-knowing stance* sounds ironic: how can a paid professional like a counselor "not know"? Isn't that what they are paid for? What do you do with all that you have learned? Does this mean you don't have to study for the final exam? Unfortunately, no.

Not knowing refers to how counselors think about what they (think they) know and the intent with which they introduce this knowing (expertise, truths, etc.) to the client. Obviously, collaborative counselors have a very particular type of knowing they are avoiding, what Anderson refers to as "pre-knowing" (Anderson, 2007). It's the type of knowing that in the vernacular is called *assuming*, believing that you can fill in the gaps or that you have enough information without sufficient evidence. Based on a postmodern social constructionist epistemology, collaborative counselors maintain that clients with apparently similar experiences, such as "psychosis," "mania," or "sexual abuse," have unique understandings of their situations (Anderson, 1997). Each client's understanding has evolved through conversations with significant others, acquaintances, professionals, strangers, as well as the larger societal discourse and stories in the media and literature. Counselors choose to *know with* and *alongside* clients as they engage in a process of better understanding clients' lives (Anderson, 2007). Counselors view the client's knowledge as equally valid to their own.

This not-knowing, not-assuming stance requires that the counselor ask what on the surface appear as either obvious or trivial questions: "You say you are sad about the loss of your mother; can you tell me what aspects of her loss touch you most deeply?" or "Tell me how you experience that sadness in your daily life." When clients begin to explore alongside the counselor the ideas, experiences, and influences that led to the perception of a problem, they often hear themselves saying things they have never told anyone before. Hearing these thoughts aloud for the first time inevitably shifts their perspective of the situations, sometimes subtly and sometimes dramatically. These new perspectives inherently inform new action and identities related to the problem (e.g., from viewing her mother as an entirely separate person, the client may shift to seeing that she is part of how her mother lives on).

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Rumor Has It: The People and Their Stories

Harlene Anderson and Harry Goolishian Harlene Anderson and Harry Goolishian developed collaborative language systems with their colleagues at the University of Texas Medical Branch in Galveston and later the Houston-Galveston Institute (Anderson, 1997, 2005, 2007). Their collaborative approach has its roots in the early model developed by the Galveston group called multiple impact therapy, a multidisciplinary approach to working with hospitalized adolescents, their families, and the broader social system. Initially their work at the Galveston Medical Center was based on the systemic ideas from the Mental Research Institute (MRI, see Chapter 11). However, over time they began to listen differently to what clients were saying, rather than trying to learn the clients' language, to use it as a strategic tool. They noticed that rather than the *family* having its own unique language, each *member* of the family seemed to have his or her own language, using words and phrases with unique meanings.

They became increasingly interested in hermeneutics, social constructionism, and postmodern ideas, including Lyotard's postmodern ideas, Berger and Luckman's social construction theory, and to the work of others, particularly Ludvig Wittgenstein, Mikhail Bahktin, Ken Gergen, and John Shotter; they began to conceptualize their work from a postmodern perspective, focusing on the construction of meaning in relationships. In addition, they had a mutually influencing relationship with Tom Andersen over the years. Over time, their counseling has been referred to as collaborative language systems (Anderson, 1997) and more recently collaborative therapy (Anderson & Gehart, 2007). After Harry's death in 1991, Harlene and her colleagues at the Houston Galveston Institute have continued developing this internationally practiced approach. Ken Gergen, Harlene Anderson, Sheila McNamee, and others joined together to form the Taos Institute, an organization of collaborative practitioners working in the fields of education, business, consultation, counseling, medicine, and other disciplines. Having found that the assumptions on which collaborative language system is based have applications beyond counseling systems, Harlene currently refers to her work as collaborative practices.

Tom Andersen No relation other than a close friend to Harlene (note the "e" versus the "o" in Andersen), Tom Andersen is a Norwegian psychiatrist who is best remembered for his gentle demeanor, his respect for client privacy, and his elegant theory. Having originally studied with the Milan team using one-way mirrors, Tom transformed the systemic practice of the observation team, using postmodern sensibilities that reduced the team-client hierarchy and made the process a dialogic rather than strategic one. His description of *inner and outer dialogues* as well as *appropriately unusual comments* provide collaborative counselors with very practical concepts that can be used to facilitate counseling conversations without the use of technique.

Lynn Hoffman Known for her keen theoretical insights and broad vision, Lynn Hoffman has worked closely with many of family therapy's most influential thinkers, including Virginia Satir, Jay Haley, Paul Watzlawick, Salvador Minuchin, Dick Auserwald, Gianfranco Cecchin, Luigi Boscolo, Tom Andersen, Harlene Anderson, and Peggy Penn. Her first book, *Foundations in Family Therapy* (Hoffman, 1981), provides one of the most comprehensive overviews of systemic family counseling available. She began learning about family approaches at MRI, serving as an editor for Satir's books. She was so inspired by the ideas that she went on to pursue a career as a social worker, training in systemic family therapies. She befriended the Milan team and, along with Peggy Penn, helped further their later development of the model (Boscolo, Cecchin, Hoffman, & Penn, 1987). In her later years, she became increasingly attracted to postmodern, collaborative approaches (Hoffman, 2001). She has detailed her remarkable journey in *Family Therapy: An Intimate History* (Hoffman, 2001), a favorite with my students who want to learn about the theories of family counseling yet prefer a little more "juice" and excitement than is offered in a textbook such as this.

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Peggy Penn A former training director of the Ackerman Institute and published poet (Penn, 2002), Peggy Penn has developed unique approaches to using writing in collaborative language systems (Penn, 2001; Penn & Frankfurt, 1994; Penn & Sheinberg, 1991). Like Hoffman, Peggy began her training in systemic therapies, most notably the Milan approach (Boscolo et al., 1987), but her work has since evolved to a more postmodern approach. She uses various forms of writing in counseling to help clients access multiple voices and perspectives.

Jaakko Seikkula Psychologist Jaakko Seikkula and his colleagues (Haarakangas, Seikkula, Alakare, & Aaltonen, 2007) have developed and researched the open dialogue approach to working with patients having psychotic symptoms in Finland. Since instituting this collaborative approach for working with psychosis over 20 years ago, there are no longer chronic cases of psychosis in the Lapland region of Finland served by their hospital, with patients with psychotic symptoms needing fewer medications and returning to work at a higher rate. Jaakko's research provides some of the best empirical evidence for postmodern therapies.

Big Picture: Overview of Counseling Process

Collaborative counselors do not have set stages of counseling or an outline for how to conduct a session. Instead, they use a single guiding principle: facilitate *collaborative relationships and generative, two-way dialogical conversations*, regardless of topic and participants. In short: keep the dialogue going. The key to facilitating dialogue is avoiding monologues.

Avoiding Monologues and Impasse

Harry Goolishian often said that it is easier to identify what *not* to do as a counselor than what to do. Extending this logic, collaborative approaches are often easier to understand by identifying what is *not* a collaborative conversation, which is namely a *monologue* (Anderson, 1997, 2007). A monologue can be an out-loud conversation with others or a silent conversation with oneself or imagined other. A spoken monological conversation consists of two people trying to sell their idea to the other person: a duel of realities. In a monological conversation, participants listen only long enough to plan their next defense—they are not trying to understand the other out of genuine interest. In silent conversations, monologue refers to the same description, opinion, and so on, consistently occupying one's thoughts, leaving no room for new ones or curiosity, and being closed to the other.

In counseling, monological conversations lead to a *therapeutic impasse*, at which point the counseling discussion no longer generates useful meanings or understandings. For most, it is easy to identify monological conversations because there is a tension and the sense that the conversational task is to convince the other of a particular point. In addition, counselors may begin to have pejorative descriptions of clients such as "resistant." When this happens—whether between counselor and client or between any two people in the room—the counselor's job is to gently shift the conversation back to a dialogical exchange of ideas. Counselors can achieve this by shifting back into a curious stance—asking to better understand the client's perspective or to inquire if there is a particular point that the client thinks the counselor is not fully understanding. However, for a counselor to reengage others in dialogue, the counselor must be in an internal dialogic mode himself or herself. In the simplest terms, a collaborative counselor's primary job is to ensure that the conversations in the room—whether between members of the client system or between the counselor and the client—do not become dueling monologues. As long as conversations are dialogical, change and transformation are inevitable.

Making Connection: Counseling Relationship

Philosophical Stance

Collaborative counselors conceptualize counselors' position as a *philosophical stance*, which refers to their particular *way of being in relation with others*. Counselors'

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philosophical stance informs how they speak to, think about, act with, and respond to clients in session. The philosophical stance focuses counselors' attention on the *person* of the client, shifting attention away from roles and functions. The philosophical stance essentially encompasses a sincere embodiment of the postmodern, social constructionist ideas that inform the collaborative approach, such as viewing the client as expert and valuing the transformative process of dialogue.

Conversational Partners: "Withness"

The counseling relationship in collaborative language systems is best described as a *conversational partnership* (Anderson, 1997). It is fundamentally a process of being *with* the client, respecting the client's knowledge and expertise, and responding in a collaborative and dialogical mode. This way of relating is sometimes referred to as "*withness*" (Hoffman, 2007), where the conversational partners "touch" one another, their understandings, and meanings *in* their responsive expressions. Withness also involves a willingness to go along for the roller-coaster "ride" (Anderson, 1993)—the ups and downs—of the client's transformational process, regardless of how uncomfortable, unpredictable, or scary it may be—a palpable commitment to walk alongside the client no matter where the journey leads.

Curiosity: The Art of Not Knowing

A hallmark of the collaborative counseling stance (Anderson, 1997), "curiosity" refers to the counselor's sincere interest in the client's unique life experiences and the meanings that are generated from these experiences. The curiosity of a collaborative counselor is fueled by a *social constructionist epistemology* (assumptions about knowledge and how we know what we know), which posits that each person constructs a unique reality formed in the webs of relationships and conversations in which they are engaged. Thus, no two people experience marriage, parenting, depression, psychosis, or anxiety the same: each has unique experiences and meanings that constitute his or her lived reality of the situation.

Client and Counselor Expertise

In 1992, Anderson and Goolishian radically proposed, "The client is the expert." Although sometimes misunderstood to mean that the counselor has no opinion and no role in the process whatsoever, the concept of "client as expert" helps focus the counselor's attention on sincerely valuing the clients' thoughts, ideas, and opinions about their lives. Clients are viewed as being the experts on their lives because counselors ultimately have very limited information about the fullness and complexity of clients' lives, whereas clients have a more complete history and "insider" perspective that counselors can never acquire to the same degree (Anderson, 1997). Thus, the concept of "client as expert" is more about the general attitude of deep, personal respect for the client than a description of how the counseling process is conducted.

In terms of the in-session process, the counselor is considered to have the greater expertise, meaning that the counselor is responsible for ensuring that an effective and respectful dialogical conversation is conducted. The counselor is responsible for the quality of the dialogue, relying on the generative quality of the conversation to support client transformation rather than the counselor dictating the content, direction, or outcome of the conversation.

In broad strokes (which are always inaccurate), it may be helpful in the beginning to think of the client as holding more expertise in the area of *content* (what needs to be talked about) and the counselor as holding more expertise in the area of *process* (how things are talked about); however, as a *collaborative process*, both counselor and client have input on both content and process. If the counselor believes that the client is not addressing an important area of content, a collaborative counselor would nonhierarchically raise the issue: "I know you prefer not to talk about the past, but I wonder if it might not be worthwhile to spend a little time exploring how your childhood abuse affects your marriage today." Such a comment is offered in such a way that the client feels truly free to say yes or no, and the counselor honors the client's wishes.

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Conversely, the counselor is also open to client feedback about the counseling process, allowing client input on which processes work best for them, including who is in the room, the pacing, the types of homework/suggestions, the types of questions, and so on. The counselor does not necessarily take the client's request as a dictate for how to do counseling, but the counselor thoughtfully considers the request and the need that underlies it and works to find ways to address it as best as possible. This back-and-forth exchange is a sincere partnership in which the counselor works side by side with the client to find useful ways of talking. Anderson (1997) talks about this continual openness to client feedback as "research as part of everyday practice." The counselor uses the feedback from the client and what is developed in discussion about it to fine-tune the counseling process as they go along in counseling, lessening the opportunity for a counseling impasse and ensuring that counseling is tailored to each client and his or her unique needs.

Everyday, Ordinary Language: A Democratic Relationship

Collaborative counselors listen, hear, and speak in a natural, down-to-earth way that is more congruent with the client's language and more *democratic* than hierarchical (Andersen, 1991; Anderson, 2007). Although they are responsible for facilitating a dialogical process that clients find useful, they do not approach the task from a position of leadership or expertise. Instead, they assume a more humble position, using everyday language, a relaxed style, and a willingness to learn that invites clients to join them in a joint exploration of how best to proceed.

Inner and Outer Talk

Tom Andersen conceptualized conversations as involving both *inner and outer talk* (Andersen, 2007). In a conversation, we most quickly recognize the *outer talk*, the verbally spoken conversation between the counseling participants. Andersen also recognized that there were other dialogues going on, namely, *inner talk*, the thoughts and conversations each person has within while participating in a conversation. Thus, if the counselor is working with one client, there are at least three conversations that are simultaneously occurring: (a) the client's inner dialogue, (b) the counselor's inner dialogue, and (c) the outer spoken dialogue. The counselor needs to allow space and time for each one of these conversations.

The counselor allows space for clients to engage in their inner dialogues because, as Andersen (2007) pointed out, when clients are speaking, they are speaking not only to the counselor but also, more importantly, *to themselves*. Often in counseling, clients are saying something aloud for the first time, and they may need time to reflect on the weight or unexpected content of what they hear themselves saying to the counselor. Andersen strongly admonished counselors to not pressure clients to share their inner dialogue, as is common in some traditional counseling approaches. Thus, if a client did not want to speak about her sexual abuse or a difficult relationship, the counselor does not force the issue but instead leaves an open invitation for the client to speak about it when ready. Rare in the field of counseling, Andersen was a champion for client privacy and autonomy *in session*, which was fueled by an abiding faith that clients have the abilities to navigate their lives in a way that works best for them.

In addition to tracking the outer dialogue with the client, Andersen encouraged counselors to track their inner dialogues: their thoughts, feelings, and reactions to the client and outer dialogue. The counselor's inner dialogue provides many forms of information that can facilitate the counseling relationship: the counselor's reaction to the client may provide information about how others are relating to the client, or it may indicate that the counselor is reacting to the client based on personal history or issues rather than on professional knowledge. The counselor's inner dialogue might also include insights, ideas, or metaphors that might further the outer dialogue.

In cases where the counselor's inner dialogue is distracting from the outer conversation, the counselor is encouraged to bring up the issue with the client, if doing so furthers the dialogue in useful ways (Anderson, 1997). For example, if a client is talking and continually minimizes the role of alcohol in his pattern of one-night stands and yet

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in each incident the counselor notices there is a clear link, the counselor can *gently* put forth her observation while verbally and nonverbally giving permission for the client to maintain his opinion without feeling as if the relationship is threatened (e.g., "I know from past conversations you don't think there is a link here, but I want to say that I keep seeing a link between your nights out partying and getting into these relationships you later regret. If you do not see alcohol as the main cause, is there a minor role it might be playing?"). The key is to offer the perspective in such a way that invites curiosity rather than defensiveness.

The Viewing: Case Conceptualization

Case conceptualization in collaborative language systems involves two key questions:

- *Who* is talking about the problem?
- *How* does each understand the problem?

Counselors answer the first by assessing who is in the *problem-organizing system*, or who is in conversation with whom and about what. The second question is approached using the counselor's *philosophical stance* to understand the client's worldview.

Who's Talking? Problem-Organizing, Problem-Dissolving Systems

Anderson and Goolishian (1988, 1992) initially conceptualized counseling systems as *linguistic systems* that organize around the identification of a problem: counselors and clients come together because someone has identified a problem, issue, or concern; the word "problem" may not always be explicitly used by the client. They referred to these systems as *problem-organizing, problem-dissolving systems*. Counseling systems are *problem organizing*, coming into being only after someone has identified a problem. Counseling systems are *problem dissolving* in that they *dissolve* when the participants—counselors, clients, and interested third parties—no longer have a problem to discuss. Additionally, "dissolving" refers to the idea that the problem often is not "solved" in the traditional sense of finding a solution. Instead, the participants' understandings *evolve* through dialogue, allowing for new thoughts, feelings, and actions. In the end, the client may not feel that the problem was "solved" as much as it dissolved. For example, if a client initially reports feeling stressed because of a recent breakup, the problem is not "solved"; rather, the client comes to interpret the situation differently and therefore acts and feels differently.

Aware that all persons talking about the problem are part of the *problem- organizing, problem-dissolving system*, collaborative counselors ask about the following:

Assessing the Problem-Organizing, Problem-Dissolving System

- Who is talking about the problem in session and outside of session?
- How does each define it?
- What does each think should be done about it?

Try It Yourself

Either alone on paper or with a partner in dialogue, use the above questions to assess the problem-organizing system. What similarities and differences do you notice in these multiple descriptions?

As the understanding of the problem shifts and evolves through dialogue, the counselor continually assesses who is involved in talking about it outside of session and inquiring about the multiple perspectives about the problem, encouraging all perspectives to be heard without trying to reconcile them or identify the "truth." By allowing multiple, contradictory perspectives to constantly linger in the air, clients and counselors

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are most likely to generate new and more useful perspectives. Thus, in the case study at the end of this chapter, the counselor seeks to understand not only the identified patient's perspective, the teen, but also her siblings, mother, mother's girlfriend, teachers, school counselor, and friends.

Philosophical Stance: Social Constructionist Viewing

Collaborative counselors' primary "tool" in counseling is not a technique or intervention but a system of viewing, their *philosophical stance* (Anderson, 1997). Collaborative counselors work from a social constructionist, postmodern perspective, which maintains that our realities are constructed in language and through relationships. Rather than seeing identities and meanings as fixed, social constructionism describes how we engage in a constant process of revising and reinterpreting our personal identities and social realities by the way we tell ourselves about what it means to be "a good person," "happy," "successful," "cared for," "living a meaningful life," "respected," and so on. These stories are shaped by conversations with friends, news stories, fiction pieces, and any exchange of ideas, whether in person or through media. The counselor's philosophical stance informs a curiosity about how clients construct their understandings of the world, rather than determining how clients are "incorrect" or "off" compared to the counselor's preferred psychological theory. Thus, the counselor's focus is always on *how clients construct meaning about the events in their lives.*

Assessing the Client's Worldview

When talking with clients, collaborative counselors focus on better understanding a client's worldview, their system for interpreting the events of their lives. Grounded in a social constructionist perspective, counselors do not approach a client's worldview looking for "errors" or even "the source of the problem"; rather, they approach clients with a gentle, nonjudging curiosity, much like a child exploring a tide pool for the first time, careful not to crush the intriguing creatures in this fascinating new world (Anderson, 1997; Hoffman, 2007). In exploring the client's worldview, the counselor is looking not for right or wrong but rather for the internal logic that makes the client's world, hopes, problems, and symptoms make sense. For example, if a woman is feeling as though her marriage is failing, how did she first get this idea? How did she respond? How did she make sense of her partner's changing behaviors and her own? What does she fear it says about her as a person? What does she think happened, and what does she see as the options from here? Why did her marriage work up until now, and what would it take to get it back to where it was or better? Such questions would not be in the counselor's tool bag; rather, they would be responses that remain congruent with the conversation at any point. "Assessment" in collaborative language systems is a continuous "coassessment." It is not separate from the conversational process, and it involves exploring questions and curiosities to understand how the client constructs her understanding of the issues and potentials for moving forward.

Targeting Change: Goal Setting

Self-Agency

Like other postmodern approaches, collaborative counselors do not have a predefined model of health to which they steer all clients in cookie-cutter fashion. Instead, the overall goal of collaborative language systems is to increase clients' sense of *agency* in their lives: the sense that they are competent and able to take meaningful action. Anderson (1997) believes that *agency* is inherent in everyone and can only be *self-accessed*, not given to by someone else, as is implied in the concept of client "empowerment"; instead, collaborative counselors see their role as participating in a process that maximizes the opportunities for agency to emerge in clients.

Transformation

Rather than conceptualizing the output of counseling as "change," collaborative counselors conceptualize the process as *transformation*, emphasizing that some "original"

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aspects remain while other aspects are added or diminished. In counseling, clients' narrative of self-identity, who they tell themselves they are, is transformed through the dialogical process, opening new possibilities for meaning, relating to others, and future action. This transformational process is not controlled or directed by the counselor but emerges from within clients as they listen to themselves, the counselor, and others share their ideas, thoughts, and hopes.

Similar to feminists, collaborative counselors maintain that the process of transformation through dialogue is inherently and inescapably *mutual*. When counselors participate in dialogical conversations, they risk being changed themselves, because the same dialogical process that allows clients to change creates a context in which the counselor will also be transformed (Anderson, 1997). The counselor's transformation may not be as dramatic or immediately evident, but by engaging in a sincere two-way exchange of ideas, the worldview of counselors inevitably evolves and shifts as they learn from their clients about other ways to make sense of and engage life.

Setting Collaborative Goals

As the name implies, counseling goals that would be included in a treatment plan are constructed *collaboratively* with clients using their everyday language rather than professional terms. In collaborative language systems, goals are conceptualized as continually evolving as meanings and understandings change. The evolution of goals may be small—from getting out to see friends or picking up painting again—or dramatic—from stopping violent outbursts to focusing on emotionally connecting with one's parent. Counselors do not have a set of predefined goals they use with all clients. Instead, goals are negotiated with each client individually.

Examples of Working Phase Goals to Address Presenting Problems

- Increase reengagement in "old me" activities.
- Connect with friends who support and listen to me.
- Reduce "mountain-out-of-a-molehill" thinking.

Examples of Closing Phase Goals That Target Agency and Identity Narratives

- Increase sense of agency and assertiveness when relating to colleagues at work.
- Increase sense of agency and ability to prioritize where my time and energy goes.
- Develop a sense of identity that honors the difficulties of the past without living in the shadow of the past.

The Doing: Interventions and Ways of Promoting Change

Conversational Questions: Understanding from Within the Dialogue

Conversational questions refer to questions that come naturally from within the dialogue rather than from professional theory (Anderson, 1997). They are not canned or preplanned but instead follow logically from what the client is saying and are generated from the counselor's curiosity and desire to understand more. For example, if a client reports feeling anxious, the counselor would ask questions that logically flow from the conversation in the moment, such as "When and about what do you feel most anxious? How long have you worried about such things?" rather than using theoretically informed questions such as behavioral functional analysis (see Chapter 9), Gestalt body awareness questions (see Chapter 8), solution-focused miracle questions (see Chapter 12), externalizing questions in narrative (see following text), or systemic interaction questions in the systems approach (see Chapter 11).

Using the client's preferred words and expressions, counselors ask conversational questions to better understand the client's lived experience; by doing so, both the counselor and the client develop a better understanding of the client's lived experiences. In research on the counseling process, clients reported that questions asked out of genuine curiosity are received quite differently than "conditional" or "loaded" questions, which are driven by a professional agenda to assess or intervene (Anderson, 1997).

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Collaborative counselors use conversational questions in a spirit of honest curiosity without a subtext or hidden professional agenda. In the case study at the end of this chapter, conversational questions are used to explore Elan's experience of his friend's death and his alcohol abuse, rather than to impose professional and political views, stereotypes, and values onto his situation.

"Appropriately Unusual" Comments

Developed from his work with reflecting teams, Tom Andersen (1991, 1995) recommends counselors avoid comments and questions that are "too usual" or "too unusual" to promote collaborative conversations. Comments that are *too usual* essentially reflect back to the client's worldview, offering no possibility for generating new understanding. Thus, agreeing to or reflecting back the client's current perspective is not likely to promote change. Alternatively, comments that are *too unusual* are too different to be useful in developing new meanings. Some clients give immediate signals that a comment is too unusual by becoming "resistant," reexplaining themselves, or rejecting the comment or suggestion. Other clients will give little indication in session that the comment is too unusual but afterward will not follow up on the comment and may even lose faith in the counselor and counseling process.

With the "just right" taste of the third bowl of porridge in the Goldilocks fairy tale, *appropriately unusual* comments clearly fit within the client's worldview while inviting curiosity and perhaps offering a new perspective that is easily "digestible" to the client. For example, if a client comes in feeling overwhelmed with a new job that is more multifaceted than the previous job, an appropriately unusual response from the counselor might be, "It sounds like your new job may require skills in multitasking and prioritizing that weren't necessary in your old job," which speaks to their current experience while offering a slightly different perspective. Such comments capture the client's attention because they are familiar enough to be safe and viable yet different enough to offer a "fresh" perspective (Anderson, 1997).

Listen for the Pause When clients hear an appropriately unusual comment, suggestion, or question, they most always have to *pause* and take time to integrate the new perspective with their current perspective; in these moments, it is most important for the counselor to allow the client time for *inner dialogue*. Sometimes a client says, "I have to think about that" or "I never thought of it that way." In response to an appropriately unusual question, a client's initial response may be, "I don't know"; given a few moments to reflect on the new idea, the client usually begins to generate a response that reflects thoughts and ideas that the client has never had before.

How Far to Go? How unusual is appropriately unusual? The trick here is that each client needs a different level of unusualness, or, alternatively stated, each client finds a different level of difference useful for generating new ideas. I often find that when I am first working with a teen, mandated client, or someone unsure of counseling, appropriately unusual comments cannot include significant differences from the client's current worldview until he or she has developed greater trust in the counselor. Additionally, the more emotionally distraught a person is, the less useful he or she finds highly unusual comments. Some clients require and prefer that the counselor deliver comments that are quite different from their own, often in a very direct manner that verges on being socially impolite. I have had clients, particularly men, say to me, "Just tell me where you think I got it wrong" or "Just tell it to me straight—don't sugarcoat it—I hate when counselors do that." Thus, appropriately unusual depends on the client's preferred style of communication and the quality of the counseling relationship. Collaborative counselors fine-tune their communication skills to deliver a range of appropriately unusual comments and carefully observe client responses to assess whether the comments are useful to clients.

Mutual Puzzling

Collaborative counselors invite their clients to join them in becoming curious about their lives in new ways: this process is referred to as *mutual puzzling* (Anderson, 1997).

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Anderson suggests that when the counselor's curiosity becomes contagious, clients are naturally invited into it. What begins, therefore, as the counselor's one-way inquiry shifts to a joint process. When clients join counselors in the meaning-making process, their rate of talking may slow down, there may be more pauses in the conversation, and there is an inquisitive yet hopeful air to the conversation. Often, the shift in clients is visible: their body posture softens, the head may tilt to the side, and they move more slowly or more quickly (Andersen, 2007). Mutual puzzling can occur only when counselors are successful in creating a two-way dialogical conversation in which both parties are able to sincerely take in and reflect on the contributions of the other.

For example, if a client lives in daily fear of having another psychotic episode after not having one for over ten years, and says that it is her illness that keeps her from moving forward in life, the mutual puzzling process may be sparked by a question, such as "That's interesting. You say you haven't had an episode in ten years, so hallucinations don't seem to be plaguing you these days. But it does sound like the *worry about* hallucinations is the problem at this point. Do you think of this as part of the original problem, or is it a new problem that developed only after the first was resolved?" In this case, a new distinction is highlighted, and the client is invited to kick it around and see what, if any, new ideas emerge and to follow where they lead. The counselor does not politely insist that worrying is the new problem but rather listens for how the client made sense of the comment and continues to follow the client's thinking, kicking around the next idea that evolves from the conversation—the counselor always most curious about how the client is making sense of what is being discussed.

Being Public: Counselor's Inner Dialogue

In *being public*, counselors share their inner dialogue for two potential reasons: (a) to respect clients by honestly sharing their thoughts about significant issues affecting treatment and (b) to prevent monological conversation by offering private thoughts into the dialogue where clients are at risk for change (Anderson, 1997, 2005). When counselors make their perspectives publicly known, they do so *tentatively* and, even when discussing professional knowledge, are careful to not overshadow the client's perspective (Anderson, 2007).

This generally occurs in two situations: (a) communication about professional information with clients or outside agencies or professionals (e.g., courts, diagnosis, psychiatrists, etc.) and (b) significant differences in values, goals, purposes, and such with the client. It is important to note that being open with one's silent thoughts also helps prevent the counselor from slipping into a monological mode. The counselor's act of speaking his or her words puts him or her into the conversation for the client to respond to, and in the act of forming silent thoughts into spoken words, something different may be created for the counselor as well.

Being Public with Professional Communication Whenever collaborative counselors handle professional matters, such as making a diagnosis, speaking with a social worker, filing a report with the court, and so on, they "make public" their thoughts, rationales, and intentions by discussing them directly with clients. Openly discussing (a) what the counselor will reveal in an upcoming conversation with another professional and/or (b) recapping what happened in the last conversation goes against traditional procedures in which communications between professionals were kept confidential *from the client*, ostensibly because they could *do harm* to the client to know what professionals were thinking; the apparent "harm" was usually that the client would be angry if he or she knew what the counselors and other professionals were *actually* thinking.

In dramatic contrast, collaborative counselors have been vanguards in lifting the veil on dialogue between professionals, engaging in honest, direct conversation with clients about the contents of these conversations. Such conversations are not always easy, such as when a counselor has to tell a client that she cannot recommend unification through child protective services until x, y, and z happen (e.g., typically spelled out by the social worker or court). Rather than the past practice of the parent learning this in court or from a social worker, the counselor has an up-front conversation from the beginning, clearly laying out the types

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of behaviors that need to be seen for the desired recommendations, and then wholeheartedly and enthusiastically working with the clients to reach this goal.

Most clients greatly respect the counselor's honesty and integrity and respond with increased motivation to make needed changes, and they fully understand when they are not given the report they hoped for because the counselor and client have been discussing progress—or lack thereof—consistently along the way. When working with court-mandated clients, St. George and Wulff (1998) have developed the practice of having the clients do the first draft of letters to the courts about the progress, including clinical recommendations, with the counselors then using the letter as a means to discuss progress and goals.

Similarly, when managing dangerous situations, the counselor "makes public" concerns about safety and the potential for harm. By inviting clients—especially those not fully invested in stopping the problem behavior—into a discussion to address the counselor's concern about the client's safety, the client and counselor can work together to develop a plan that is meaningful to the client while addressing the counselor's safety concerns and following legal and ethical mandates.

Being Public with Significant Differences in Values and Goals The other situation in which collaborative counselors make public their voice is when there are significant differences in values or goals that make it hard for the counselor to move forward as an active participant in the conversation. For example, I recently had a teenager discuss his plans to meet someone who had challenged him to a fight at a park that day, saying, "Don't bring weapons or friends." The teen believed that if he didn't show up, more guys at school would gang up on him, and that could lead to more events such as this. Although I saw his point, I also saw how he was at risk for seriously being hurt, a concern I decided to make "public." I invited him to explore my concerns: the guy might come with friends or weapons, and/or there might be legal ramifications and so on. I offered my list of dangers from a place of serious concern without demanding a particular course of action on his part. Instead, I asked him how he would manage the dangers I saw; by the end of the conversation, we arrived at a place where my concerns and his were addressed and where both of us felt good about his chosen course of action, namely, to avoid the park that day and to try to find out about this person's social network. Similarly, the counselor in the case study at the end of this chapter uses being public to share his concerns about Elan's safety when using substances, to develop a safety and harm-reduction plan.

Accessing Multiple Voices in Writing

Peggy Penn and her associates (Penn 2001; Penn & Frankfurt, 1994; Penn & Sheinberg, 1991) access multiple, alternative voices using various forms of writing (i.e., letters, poems, and journals) to generate alternative perspectives and make room for silenced inner voices or the voices of significant persons not currently in the counseling dialogue. Penn and Frankfurt (1994) have found that "writing slows down our perceptions and reactions, making room for their thickening, their gradual layering" (p. 229). They have also found that the performative aspect, the reading aloud of letters to witnesses (the counselor, family, and others), makes things happen. Penn's writing has a different intent than writing in experiential therapies, which are meant to express repressed emotions, bring resolution to a past situation, or achieve a similar clinical aim. Instead, Penn's writing invites different voices into the conversation to generate alternative possibilities for understanding. Furthermore, writing promotes agency: "to write *gives us agency*: *we are not acted on by a situation, we are acting!*" (Penn, 2001, p. 49; emphasis in the original). Writing in collaborative counseling may involve asking clients to write the following:

- Letters to themselves from aspects of themselves and/or from newly emerging, future, or past selves
- Letters to themselves from significant others, from the present, past, or future
- Letters to and from significant others (alive or dead) speaking from a voice/perspective that was formerly kept private

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- Letters or journal entries to speak from parts of the self that are typically not expressed and/or are emerging in counseling
- Letters to the world or general audience
- Multivoiced biographies that describe one's life from various perspectives
- Poems that express inner voices and perspectives that are not readily articulated other ways

Try It Yourself

Pick one of the above writing exercises to explore multiple voices related to a situation.

Reflecting Teams and the Reflecting Process

Tom Andersen trained at the Milan Institute, where a small team of counselors would observe the counselor talking with families behind a one-way mirror, the preferred method for interviewing in early family counseling. Influenced by postmodern thinking, Andersen (1995) and his colleagues wanted to make the process more *democratic* and developed the idea of having the families listen to the team's conversation behind the mirror; thus, the reflecting team practice began. With the earliest reflecting teams, the family and team would literally switch rooms if sound could be heard in only one room or turn off the lights in the family's room and turn on the lights in the team's room, reversing the one-way mirror. In later years, the team was invited to sit in the *same room but separate from* the family and counselor having a conversation. Over the years, the practice has developed more into a general *process* of reflecting that is used for talking with clients with or without a team.

The idea behind a collaborative reflecting team is to develop *diverse* strands of conversation, and for the client to choose that which resonates and that which does not. Collaborative reflecting teams avoid coming to agreement on any one description of what is going on with the client, allowing for *multiple, contradictory perspectives* to linger and promoting the development of new meanings and perspectives. Teams avoid comments that evaluate or judge the client in any way, positive or negative. Instead, the focus is on offering what are called *reflections*, observations, questions, or comments that are clearly owned by the person making it (e.g., "As I listened, I was wondering …").

General Guidelines for Reflecting Teams

Andersen (1991, 1995) provides guidelines for teams:

- *Use only with the permission of the client:* The counselor should obtain the client's permission to use a team *before* the session starts. When the counselor has a strong rapport with the client and confidently explains how the reflecting process works, most clients enthusiastically agree.
- *Give the client permission to listen or not to listen:* Andersen gives the clients *explicit* permission to listen or not listen. I find it helpful to tell clients that they will probably hear some comments that resonate deeply and others that fit less well with their experience, and recommend that they focus on the comments that "strike a chord."
- *Team members should speak from something they see or hear in the family's talk with the counselor,* not *what is observed:* Comment on a specific event or statement in the conversation and then "wonder" or be "curious" about it. The wondering or curiosity statement should be *appropriately unusual* to help generate new perspectives.
- *Talk from a questioning, speculative, and tentative perspective:* Team members avoid offering opinions or interpretations and instead use "wondering" questions (e.g., "I am wondering if …") or offer a tentative perspective (e.g., "I am aware I don't know enough to know the whole story, but it seems like there might be …"). If a team member offers a strong opinion, another team member may ask, "What did you see or hear in the conversation that made you think that?" to open the conversation up and invite multiple perspectives.

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- *Comment on all that you hear but not all that you see:* If the family tries to cover something up, allow them the *right to not talk about* all that they think and feel. Andersen warns, "Don't confuse counseling with confession." Unlike psychodynamic and humanistic traditions, Andersen is explicit that if a client wants to hide an emotion or not say something, the client should be free to do so. He was a rare advocate for client privacy in counseling, believing that clients will share when they are ready. If a counselor notices a client getting agitated or holding back tears, he does not comment on it, allowing the client to speak about these emotions when he or she is ready to do so.
- *The team and family can be in the same room, but they should not talk to each other:* Andersen believed that an important psychological space is created by the physical space between the team and client and by the two not talking directly; later research studies supported his view (Sells, Smith, Coe, & Yoshioka, 1994). This space invites all participants to focus on their inner dialogue, stimulating new thoughts and ideas more readily.
- *Listen for what is appropriately unusual and avoid what is too usual or too unusual:* To identify useful reflections, Andersen asks himself, "Is what is going on now appropriately unusual or is it too unusual?" (Andersen, 1995, p. 21).
- *"How would you like to use this session today?"* A question that a collaborative counselor is likely to ask at the beginning of any session, this question is critical when a team is involved. If the client is nervous about using a reflecting team, the counselor can also add, "Are there particular topics you want to avoid with the team here?"

Try It Yourself

Next time your class watches a video or does a role-play, try adding a reflecting team to the experience.

Related Reflecting Processes

Over time, the concept of the reflecting team has developed into a number of reflecting processes:

- *Reflecting team:* A team of two to four counselors observes the counselor-client conversation, sitting either in a different room using a one-way mirror (or camera) or in a separate space in the same room.
- *Single reflector:* If only one colleague is available, the counselor may turn and have a reflecting conversation with this one reflector while the client listens.
- *No outside reflector when working with a family:* When there is no outside colleague available, the counselor may choose to speak with a single family member while others listen.
- *No outside reflector when working with an individual:* In cases where the counselor is working with an individual client, a reflective process can be created by talking about issues from the perspective of someone who is not present (e.g., a parent, friend, spouse, famous person of personal significance, or others).
- *With young children:* When working with children, reflections can include play media; a single counselor working with an individual child can create reflecting teams using puppets or other play media (Gehart, 2007a).

"As-If" Reflecting

Developed by Anderson (1997), the "as-if" reflecting processes involves having the team members or other witnesses to the conversation speak, or reflect, "as if" they are one of the people in the problem-organized system (i.e., one of the people talking about the problem), which includes the client, family members, friends, bosses, teachers, school personnel, medical professionals, probation officers, and so on. This process can be used with families or with supervisees staffing a case.

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Putting It All Together: Collaborative Treatment Plan Case Conceptualization and Treatment Plan Templates

Theory-Specific Case Conceptualization: Collaborative

- *Who's Talking about the Problem: Multiple Definitions of the Problem*
  - Client's definition of the problem
  - Extended family's definition of the problem
  - Broader system definition (school, work, friends, etc.)
- *Social Construction of Problem*
  Describe client's significant meanings and constructions related to the problem (e.g., constructions of love, depression, duties of family members, etc).
- *Client's Worldview*
  Describe the client's worldview, inner dialogue, and/or narrative of the problem and/or their life/relational circumstances related to it.
- *Dominant Discourses*
  - Cultural, ethnic, SES, religious, etc.: How do key cultural discourses inform what is perceived as a problem and the possible solutions?
  - Gender, sexual orientation, etc.: How do the gender/sexual discourses inform what is perceived as a problem and the possible solutions?
  - Contextual, family, community, school, and other social discourses: How do other important discourses inform what is perceived as a problem and the possible solutions?
- *Local/Alternative Narratives*
  - Identity/Self-Narratives: How has the problem shaped each family member's identity?
- *Local or Preferred Discourses:* What is the client's preferred identity narrative and/or narrative about the problem? Are there local (alternative) discourses about the problem that are preferred?

Treatment Plan Template: Collaborative

Use this treatment plan template for developing a plan for clients with depressive, anxious, or compulsive types of presenting problems. Depending on the specific client, presenting problem, and clinical context, the goals and interventions in this template may need to be modified only slightly or significantly; you are encouraged to significantly revise the plan as needed. For the plan to be useful, goals and techniques should be written to target specific beliefs, behaviors, and emotions that the client is experiencing. The more specific, the more useful it will be to you.

Treatment Plan

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration:* [Describe how you will specifically adapt your approach to be sensitive to client diversity when developing the counseling relationship; this may include respecting cultured and gendered norms for emotional expression.]
   Relationship building intervention:
   a. Develop **conversational partnership** and sense of "**withness**" by acknowledging **client expertise**, **being curious**, and using **everyday language**.

(*continued*)

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2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Involve all parties who are talking about the problem.
   Assessment Strategies:
   a. Make room in the dialogue to hear the perspective of each member of the **problem-determined system**, which may involve inviting persons to sessions or making out-of-session phone calls to other professionals and/or family members.
   b. **Conversational questions** to develop understanding of the problem from "within" each person's worldview.

Initial Phase Client Goals (One to Two Goals): Manage crisis issues and/or reduce most distressing symptoms

1. *Increase* the client's sense of **agency** related to [crisis-triggering situation] to reduce [crisis symptom(s)].
   Interventions:
   a. **Conversational questions** to understand crisis triggers, issues, and inner experience from client's perspective.
   b. **Mutual puzzling** to collaboratively identify crisis behaviors and client's preferred means for managing; use **client expertise** to develop mutually agreed-on safety plan.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* [Describe how you monitor the client's ongoing sense of connection with counselor and how you will specifically adapt monitoring and/or relationship based on client age, gender, cultural, sexual orientation, socioeconomic status, etc.]
   Assessment Intervention:
   a. **Mutually puzzling questions** to **publicly** reflect on quality of the relationship; use Session Rating Scale with clients who find it useful.

Working Phase Client Goals

1. *Increase* sense of available perspectives and options and expand client's understanding of [the problem] to reduce [specific symptoms: depression, anxiety, etc.].
   Interventions:
   a. **Conversational questions** to generate new understandings of problem and to generate multivoiced descriptions that include perspectives of others talking about the problem.
   b. Offer **appropriately unusual comments** to enable client to generate new inner dialogues related to the problem.
2. *Increase* frequency of [specific behavior] to support the client's **sense of agency** in relation to [the problem] to reduce [specific symptoms: depression, anxiety, etc.].
   Interventions:
   a. **Mutual puzzling** to jointly identify meaningful actions, relationships, and options that support client in reaching desired goals.
   b. **Reflecting team/practices** to generate new ways of viewing and interacting in relation to the problem.
3. *Increase* frequency of [specific behavior] to support the client's **sense of agency** in relation to [another element of problem] to reduce [specific symptoms: depression, anxiety, etc.].
   Interventions:
   a. **Mutual puzzling** to jointly identify meaningful actions, relationships, and options that support client in reaching desired goals.

(*continued*)

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b. **Writing letters, poems**, etc. to generate multiple perspectives for viewing and relating to the problem.

Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity consideration:* [Describe how you will access resources in the communities of which they are a part to support them after treatment ends. Involve significant others when possible.]
   Intervention:
   a. Collaboratively identify how client can use what they have learned to prevent the future problems.

Closing Phase Client Goals

1. *Increase* client's sense of **self-agency** in relation to [the problem] to reduce [specific symptoms: depression, anxiety, etc.].
   Interventions:
   a. **Appropriate unusual comments** to highlight before-during-after process of transformation.
   b. **Reflecting practices/team** to story process of transformation from multiple perspectives.
   c. **Writing letters, poems, exercises**, and so on, to thicken descriptions of problem dissolution.
2. *Increase* client's agency/identity narrative as it relates to [another key area of life, such as relationship, work, etc.] to reduce [specific symptoms: depression, anxiety, etc.].
   Interventions:
   a. **Mutual puzzling questions** to explore how strengths and resources in one area of life can transfer to other areas.
   b. **Conversational questions** and using **client expertise** to identify how best to use agency in [other area of life].

Research and the Evidence Base

Consistent with their philosophical underpinnings, narrative and collaborative counselors have conducted more qualitative than quantitative investigations about their approaches to therapy (Anderson, 1997; Gehart et al., 2007). Qualitative research on postmodern therapies has focused on clients' lived experience of therapy and its effects on their lives, emphasizing the clients' experience over researcher-defined measures of successful therapy (Andersen, 1997; Gehart & Lyle, 1999; Levitt & Rennie, 2004; London, Ruiz, Gargollo, & M.C., 1998). A notable exception, Finnish psychiatrist Jaakko Seikkula (2002) and his team (Haarakangas et al., 2007) have used qualitative and quantitative methods to study their open dialogue approach to working with psychosis and other severe diagnoses for over 20 years, generating significant evidence for their model's effectiveness. They report that they have effectively eradicated chronic cases of psychosis, with most clients returning to normal functioning within two years; their work is an exemplary, evidence-based approach for recovery-oriented approaches to treating severe mental health issues.

Outcome research on narrative therapy has increased in recent years. For example, one study from Australia examined the effectiveness of narrative therapy for treating major depressive disorder and found its effects were comparable to other approaches, with 74% of clients achieving reliable improvement (Vromans & Schweitzer, 2011). In another Australian study, women with eating disorder and depressive issues engaged in a 10-week narrative therapy group that resulted in reduced self-criticism and changes in

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daily practices/activities. Process research on narrative therapy indicates that unique outcomes that specifically enable clients to re-conceptualize their problems and foster new experiences are correlated with positive outcomes (Matos, Santos, Gonçalves, & Martins, 2009).

The assumptions and premises of postmodern therapy are also receiving support from an unexpected arena: psychiatry, more specifically interpersonal neurobiology (Beaudoin, & Zimmerman, 2011; Gehart, 2012; Siegel, 2010). Like postmodern counselors, Siegel proposes that storytelling is how humans make sense of life:

> We are storytelling creatures, and stories are the social glue that binds us to one another. Understanding the structure and function of narrative is therapy a part of understanding what it means to be human. (pp. 31-2)

Siegel describes how in childhood, humans are born into story, take on cultural meaning, and then in adolescence and adulthood continue to reshape these meanings, thus evolving human culture. These narratives constrain or expand a person's options for responding to life. Siegel suggests that *reflection*—a detached examination of these narratives—enable clients to liberate themselves from these limiting stories of who they are and what their life is; this same process is emphasized in postmodern therapies.

In describing how people change, Siegel (2010) emphasizes the importance of *bottom-up processing*, which is compared *top-down process*. Bottom-up processing refers to processing experience using the bottom three layers of the prefrontal cortex to generate new understandings, categories, and stories for what is happening. In contrast, top-down processing involves using the top three layers of the prefrontal cortex to categorize lived experience with pre-existing categories. Both forms of processing are important, but most people who feel "stuck" related to a problem are stuck in top-down processing, unable to change how they see their situation or possibilities for changing it. The *not knowing* position of postmodern counselors is an excellent approach for facilitating bottom-up processing: in fact, the entire collaborative therapy process can be viewed as an approach for expanding bottom-up processing (Gehart, 2012).

Additionally, Siegel (2010) describes trauma resolution as a process of creating an integrative narrative, similar to thickening the plot in narrative therapy. Traumatic experiences overwhelm the hippocampus and explicit (narrative) memory not encoded with implicit memory, as happens in non-traumatic situations. Thus, traumatic memories are encoded primarily as implicit memories, which do not have a sensation of being from the past and are often experienced as fragmented auditory, visual, and sensual experiences that are occurring in the here-and-now (i.e., flashbacks). These fragmented memories create chaotic and rigid patterns that impair the brain's ability to enter into health integrated neural states. Siegel suggests that the treatment from trauma essentially involves pulling the implicit memories together into a coherent narrative, which is most easily achieved by entering into "interpersonal attunement" with a counselor. He proposes that when two minds become entrained, in sync, the client can "borrow" the counselor's neural integrated state to help cope with the traumatic memories long enough to put them into a coherent narrative. Through this process of recreating an integrated explicit narrative of the trauma the client is then able to recall the trauma while remaining in an integrated neural state (i.e., not have symptoms when recalling the trauma).

Finally, Beaudoin and Zimmerman (2011) note that the postmodern techniques that help clients "give voice" to their lived experience and put into words things that have never been said before help move clients from their anxiety-focused limbic system to the more calm and reason-focused prefrontal cortex. By labeling and giving voice to their stress-based experiences, clients are able to reduce the firing of the limbic system, allowing the client to make more conscious choices and responses. Furthermore, therapeutic conversations about preferred realities strengthen neural connections that support clients' preferred identities and associated behaviors. In particular, *affect-infused descriptions* of preferred realities help to solidify new identity narratives, which are predominantly associated with the right brain hemisphere; such affect-infused descriptions include not only emotion but also sensory experiences, such as imagery, scent, and tactile experiences.

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Tapestry Weaving: Working with Diverse Populations

Cultural and Ethnic Diversity

More than any other theory covered thus far in this book, postmodern approaches—along with feminist counseling in the upcoming Chapter 14—integrate consideration of cultural and diversity issues at the core of the approach. Therefore, many would consider them the quintessential approach for diverse populations. The broader questions of diversity and of how society, its norms, and the use of language affect individuals are the guiding premises in postmodern philosophical literature, making these therapies particularly suitable for clients from marginalized groups (see Monk et al., 2008). Unlike most mental health therapies, narrative and feminist approaches (Chapter 14) place societal issues of oppression at the heart of its therapeutic interventions, and many narrative counselors are active agents of social justice (Jordan, 1997, 2010; Zimmerman & Dickerson, 1996). Collaborative therapy attends more to local discourses, working closely with the client and significant others to determine what the problem is (for the moment, knowing its definition will continually evolve) and how best to resolve it. This focus on local knowledges ensures that the client's cultural values and beliefs are a central part of the therapy process. Postmodern approaches have international roots and are practiced in numerous countries around the world.

Applications with Native American, First Nations, and Aboriginals

Narrative therapy approaches have been widely used and researched with native cultures in Canada, Australia, New Zealand, and the United States. In one study, counselors who worked with Native Americans in Wyoming identified communication and therapy practices that seemed best suited for this culture, all of which were descriptive of narrative therapy practices (Lee, 1997). Some of the observations from these counselors include:

- *Subtle eye contact:* Native Americans generally do not maintain sustained eye contact, and counselor should follow the client's lead.
- *Active listening:* Counselors should use nonverbal and verbal feedback to signal that the client's meanings are understood.
- *Subtle emotional expression:* Native Americans are not prone to strong, demonstrative expressions of emotions, and counselors must respect this by not pushing hard for emotional expression.
- *Spirituality:* Spirituality is generally highly valued by Native Americans, and counselors need to respectfully address and find ways to integrate these practices into therapeutic work.
- *Self-in-relation:* Native Americans are likely to construct their identity within relationships, seeing much of their identity as tied to family or the tribe.
- *Home visits:* The counselor making home visits is generally appreciated by Native Americans, helpful in terms of comfort, familiarity, and time flexibility.
- *Gentle, reflective stance:* Counselors described a therapeutic stance that was calm, reflective, nonconfrontational, and nonconflictual.
- *Art, storytelling, and metaphor:* The use of art, drawing, storytelling, and metaphor were found to be particularly helpful interventions.

In another study set in Manitoba, Canada, native healers and their clients were interviewed for what they believed to be helpful in changing emotions, cognitions, and behaviors (McCabe, 2007). This study included many of the above practices in addition to:

- *Ceremonies and rituals:* Ceremony and rituals are powerful allies in the healing process and are used throughout.
- *Spiritual guidance:* Native Americans with traditional spiritual beliefs generally believe in a Creator spirit that provides guidance in the healing process.
- *Self-acceptance:* For many, themes of self-acceptance of one's identity, especially within the larger context of marginalization.

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- *Lessons of daily living:* Using opportunities in daily living to apply learning.
- *Empathy:* Expressions of empathy from the healer help in the healing process.
- *Role modeling:* The healer serves as a role model for the client in terms of lifestyle, behaviors, and attitudes.

Narrative counselors readily use native rituals, ceremonies, spiritual beliefs, and cultural stories to create therapeutic contexts that are respectful and responsive to the needs of native and aboriginal clients, often inviting tribal elders, leaders, and healers into the broader therapeutic dialogue. In particular, separating the person from the problem and meeting the person apart from the problem can be particularly useful. In addition, counselors can use situating and permission comments to increase the client's sense of voice and autonomy in the therapeutic relationship and to help create a more respectful healing context.

Hispanic Youth

Narrative counseling has also been used with Hispanic children and adolescents with depression, high-risk behaviors, and/or substance abuse (Malgady & Costantino, 2010). Some of their unique applications with this population include:

- *Cuento therapy:* Puerto Rican folktales, *cuentos*, were used to convey themes and morals to provide models for adaptive responses to problems, such as acting out, self-esteem, and anxiety. They adapted the tales to incorporate traditional Puerto Rican values as well as Anglo cultural values.
- *Hero/Heroine therapy:* As many children were in single-parent households, the counselors had children identify male and female Puerto Rican heroes and heroines to help bridge bicultural, intergenerational differences, and identify conflicts commonly experienced in adolescence.
- *Temas storytelling therapy:* Counselors selected pictures from the Thematic Apperception Tests that represented Hispanic cultural elements: traditional food, games, family scenes, and neighborhoods. Then the group of children was asked to develop a story with the cards. Then each group member was invited to share personal experiences that relate to the story the group created. The counselor reinforced adaptive, preferred narratives and helped find alternatives to maladaptive responses. Finally, the group did a dramatization of the story in class to practice preferred behaviors and responses.

Sexual Identity Diversity

Postmodern therapies are often the theory of choice for working with lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) clients because they help to deconstruct the heterosexist discourses that often are the source of greatest suffering in LGBTQ clients (Simon & Whitfield, 2000). Deconstructionist practices can help clients critically examine how their understanding of their sexuality emerged, the consequences of these descriptions, and options for alternative understandings (Simon & Whitfield, 2000). When working with LGBTQ clients, some counselors recommend an advocacy stance with expertise in the subject matter rather than a strict not-knowing stance (Aducci & Baptist, 2011; Perez, 1998). In addition, many LGBTQ clients benefit form therapeutic conversations that help them to construct positive labels and identity narratives for themselves and their relationships (Perez, 1998). Furthermore, it is important for counselors to identify how much of the presenting problem is due directly to a client's sexual identity versus more general life or relationship circumstances (Aducci & Baptist, 2011).

Narrative counselors have developed a specific approach that can be used with LGBTQ clients struggling with dissonance between heterosexual dominant discourses and their own lived experience. Yarhouse (2008) describes *narrative sexual identity therapy* as a middle ground to *gay-affirmative therapy* on one hand, which affirms the inherent goodness of identifying as LGBT, and *reorientation therapy* on the other, a highly

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controversial approach (so much so that it is under legislative scrutiny in California at the moment) designed to help clients change their sexual orientation to heterosexual. In contrast, narrative sexual identity therapy, which is based on narrative therapy principles, helps clients seek to live their lives in *congruence* between their personal beliefs and behaviors, a process that focuses on deconstructing dominant discourses that constrain and confuse clients' sexual identity. Designed to help clients struggling with their sexual identity, this approach is particularly relevant for clients from religious and cultural backgrounds that have strong anti-gay messages.

Drawing from standard narrative therapy practices, the counselor helps clients identify the problem narrative and then identify potential counternarrative that is more congruent with the client's lived experience and values. In this approach, the client determines what values and intentions they want to define their lives. The approach has six general steps or phases, which are of course fluid but can nonetheless be helpful to counselors in conceptualizing treatment.

1. *Client Presents Sexual Identity Concern*
   Initially, a client presents with concerns about sexual identity. These concerns may be related to external (e.g., religious, cultural, or family) or internal voices (e.g., personal values) that believe their lived experience of sexual attraction is somehow wrong, immoral, or otherwise problematic.
2. *Map Dominant Narratives*
   The next step is to explore the dominant discourse, its origin and specific nuanced meanings. Questions counselors can ask to map the dominant discourse include:
   - What were some of the messages you received growing up about identifying as gay? (Yarhouse, 2008, p. 205)
   - How was the message communicated to you that feelings toward the same sex meant you were gay? (Yarhouse, 2008, p. 205)
   - How did you respond to these views of same-sex attraction?
3. *Identify Preferred Narratives*
   In the next phase, clients reflect on their own personal lived experience of same-sex attraction. Most often the metaphor used to describe this is "*discovery*": discovering a preexisting fact about their true selves. In other cases, the metaphor is more one of "integration": integrating their experience of same-sex attraction with their other aspects of their identity. The metaphor of integration is more common when a person chooses not to assume a gay identity but instead chooses to integrate only certain elements.
4. *Recognize Exceptions/Emerging Counternarrative*
   Next, the counselor helps clients identify exceptions to the dominant discourses to create space for a counternarrative to emerge. Questions counselors can use to facilitate this process include:
   - In what ways are you understanding your sexual identity differently from when you first thought of yourself? (Yarhouse, 2008, p. 206)
   - Have you had experiences that call into question the meaning of same-sex attraction that you learned when you were young?
   - In what ways have your personal experiences of same-sex attraction contrasted to messages you have heard about what gay people are like?
5. *Highlight Identity-Congruent Attributes, Activities, and Resources*
   As the counternarrative emerges, the counselor listens for and highlights personal attributes, activities, and resources that are congruent with the client's preferred identity.
   - In what ways would you like to challenge some of the messages you received about your sexual identity? (Yarhouse, 2008, p. 207)
   - In what ways are you already living in accordance—even in small measure—with your preferred values and identity?
   - What type of relationships, activities, or communities might further provide support for your preferred identity and values?

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6. *Resolution/Congruence*
   Finally, clients are able to live according to their preferred sexual identity, one that is congruent with their lived experience, spiritual beliefs, and cultural values. Questions counselors can use to facilitate this process include:
   - In the course of the next few months or so, what do you see as the relationship between your sexual identity and your religious or spiritual identity? (Yarhouse, 2008, p. 208)
   - Can you share a little of the way you would like to describe your sexual identity in the year to come? (Yarhouse, 2008, p. 208)

Postmodern Case Study

A 19-year-old of Native American descent, Elan recently lost his best friend in a drunk-driving accident. His friend was driving while under the influence on his way home from Elan's house and hit a tree; he was killed immediately on impact. Because of his extreme guilt, Elan initially did not drink for several months after the accident. Now that he has resumed drinking, he is drinking more than ever before. He says that his friend's spirit is haunting him and Elan is considering contacting a medicine man whom his mother knows to help deal with the spirit. Elan says he is having trouble focusing in his retail job and just isn't motivated to stay in the community college classes he was enrolled in with his friend. Before his friend's death, he was socially active, played basketball, and wanted to be a computer technician, but now he hangs around the house, drinking beer and playing video games and rarely hanging out with his friends anymore because of his shame. His mother doesn't say much other than insisting that he keep going to work and nag him about his drinking. His younger sister tries to reach out to him, but he keeps pushing her away.

Case Conceptualization: Postmodern

This case conceptualization was developed by selecting key concepts from the "The Viewing: Case Conceptualization" sections of this chapter. You can use any of the concepts in that section to develop a case conceptualization for this or other cases.

Person Apart from the Problem

AM (adult male) describes himself before the accident as the life of the party with lots of friends, an active basketball player, and an aspiring computer technician. He also describes himself as having a "cool" family that he enjoyed hanging out with.

Problem-Saturated Stories

AM's problem-saturated story involves both personal and relational changes:

- *Personal:* Dropped out of school; stopped playing basket ball; drinking more, difficulty focusing at work; feeling too ashamed to be with friends
- *Relational:* Distant from mother; pulling away from sister and friends; feels haunted by friend's spirit

Unique Outcomes and Sparkling Events

Unique outcomes include wanting to connect with mother to find a medicine man and thereby reconnect with cultural traditions; every once in a while, agreeing to hang out with friends; and choosing not too drink so much that he is unable to go to work.

Dominant Cultural and Gender Discourses

Cultural: AM's grief experience is partially shaped by his Native American background; he says his guilt and shame are exacerbated by the sense that he has lost honor and is now living up to society's story of being an "alcoholic Indian."

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Gender: AM's partying fits with dominant discourses about how young males, including Native Americans, "have fun." His guilt around his friend's death implies that he knew his friend was taking a risk driving home but that he probably didn't want to appear wimpy and tell him not to drink and drive.
Social and Community: Within his tribal community, he feels some renewed connection due to being haunted by his friend and also feels increased shame because of his part in the death and his becoming connected with alcohol.

Local and Alternative Discourses: Attending to Client Language and Meaning

AM's experience of feeling haunted by his friend's ghost is more common in Native American populations, as is his desire to seek a medicine man to help with this situation. Since no other psychotic symptoms are reported, his experience of spirits can be considered within cultural norms (assuming it is not better explained by substance use).

Who's Talking? Problem-Organizing, Problem-Dissolving Systems

In terms of assessing the problem-organizing system, it is important to consider not only how AM is constructing the problem but also his mother, sister, friends, deceased friend's family, and their larger community. His mother sees the greatest problem as AM's drinking and potential to lose his job. His sister seems to see his sadness and social withdrawal as the biggest problems. His friends are also affected by his social withdrawal.

Assessing the Client's Worldview

AM sees himself as at least partially responsible for the death of his friend and seems to feel so ashamed that he does not feel entitled to pursue his life dreams, at least education and social activities, as he did before. His experience of being haunted by his friend's ghost further reinforces his sense of guilt and shame. His return to heavy drinking, after not drinking initially after the accident, seems to indicate that he has become increasingly hopeless and having difficulty managing his emotions.

Treatment Plan: Postmodern

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration:* Attend to AM's level of acculturation, especially in regard to eye contact and direct, emotionally challenging comments.
   Relationship building intervention:
   a. Meet **AM apart from the problem** (who he was before the accident) to generate **hope** and reconnect him with a sense of who he is.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Consider inviting mother, sister, and/or friends.
   Assessment Strategies:
   a. **Relative influence questioning** and **deconstructive questions** to identify effects of problem and effects of person, noting key **dominant and local discourses**, carefully attending to cultural issues.
   b. Identify **unique outcomes and sparkling moments** that do not conform to the problem-saturated narrative, such as times when he does not drink and/or he hangs out with friends.

(*continued*)

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Initial Phase Client Goals

1. *Increase* the client's ability **resist invitations** to engage in drinking to forget about accident to reduce alcohol abuse.
   Interventions:
   a. **Relative influence questioning** to identify how client is "enticed" to engage in problem-drinking behavior as well as times when the client resists these invitations.
   b. **Statement of position map** to identify client's desired "position" in relation to crisis drinking; identify strategies, persons, and contexts that support the desired position.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* Adapt alliance to acknowledge cultural norms for discussing problems and talking with a person of higher social standing.
   Assessment Intervention:
   a. Use **situating comments** and **permission questions** to situate counselor as **coeditor/investigative reporter**; regularly check in with client about alliance; use Session Rating Scale.

Working Phase Client Goals

1. *Increase* client's sense of **agency in relation** to the accident and responsibility to move forward with integrity to reduce guilt and motivation to abuse alcohol.
   Interventions:
   a. **Conversational questions** to generate new understandings of the problem and ways that the accident and loss can inform his identity moving forward.
   b. **Statement of position map** and **relative influence questioning** to externalize problem and clarify who he is, how this accident has changed him, and how best to move forward with integrity.
2. *Increase* frequency of social interactions that supports the client's **preferred reality** to reduce social withdrawal.
   Interventions:
   a. **Mutual puzzling** to identify specific behaviors that support rebuilding social connection that AM is willing to carry out.
   b. **Scaffolding questions** to help client move toward rebuilding his social network and to take responsible action within that network.
3. *Increase* motivation to return to school to pursue career goals to reduce hopelessness and depression.
   Interventions:
   a. **Mapping in the landscapes of action and consciousness** to identify specific behaviors that support successfully returning to school.
   b. **Reflecting practices** to help AM develop new meanings with returning to school in relation to the memory of his friend.

Closing Phase of Treatment

Closing Phase Counseling Task

1. *Develop aftercare plan and maintain gains. Diversity consideration:* Identify ways to engage support system.
   Intervention:
   a. Use **mapping in the landscape of action and consciousness** questions to help AM identify how he can resist invitations from alcohol and guilt.

(*continued*)

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Closing Phase Client Goals

1. *Increase* and **thicken the plot** around the AM's **new sense of identity** and **agency** in relation to the accident and alcohol to reduce guilt, alcohol abuse, and loss of interest in regular activities.
   Interventions:
   a. **Mutual puzzling** to develop action plans to bolster and sustain new identity.
   b. **Landscape of action and consciousness questions** to thicken new narratives that capture AM's outer and inner experiences as he finds meaning and moves forward after this tragedy.
2. *Increase* **involvement of mother**, **sister**, **friends**, and/or **medicine man** in AM's life to **witness and support new identity narrative** and relationship to the accident to reduce social withdrawal and depression.
   Interventions:
   a. **Invite significant persons to session** to partake in an atonement or similar ceremony that helps AM story his role in the tragedy and his atonement for his part.
   b. **Letters and/or other written documents** to document atonement and solidify new identity and preferred narrative.

Questions for Personal Reflection and Class Discussion

1. In what ways does the co-construction of reality seem to make sense to you? In what ways does it not?
2. Identify one dominant discourse that is affecting your life in a negative way.
   - Where were you first exposed to this discourse?
   - How does it affect your view of yourself?
   - What helps you to resist defining yourself by this discourse?
3. Describe a moment in your life where you felt marginalized, invisible, or oppressed.
   - How did this experience affect how you saw yourself? Does it still affect you today?
   - How did this experience affect how you saw others involved?
4. Describe the effect of dominant discourses about gender that affect you personally.
   - In what ways do you live in accordance to these? What are the effects of doing so?
   - In what ways do you not follow these? What are the effects of not doing so?
5. Does the idea of "client expertise" make sense to you? Why or why not?
6. Describe a time when a person made a comment that was:
   - Too unusual. How did you respond?
   - Too usual. How did you respond?
   - Appropriately unusual. How did you respond?

Online Resources

Institutes and Training Centers

Harlene Anderson
www.harleneanderson.org

Dulwich Centre: Michael White's Narrative Therapy
www.dulwichcenter.com

Evanston Family Therapy Center: Freedman and Combs' Narrative Therapy
www.narrativetherapychicago.com

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Houston Galveston Institute: Collaborative Language Systems
www.talkhgi.com

Narrative Approaches
www.narrativeapproaches.com

Taos Institute: Collaborative Practices in Therapy, Consultation, Education, Business
www.taosinstitute.net

Yaletown Family Therapy: Narrative Therapy, Canada
www.yaletownfamilytherapy.com

Client Site

Anti-Anorexia/Anti-Bulima League
www.narrativeapproaches.com/antianorexia%20folder/anti_anorexia_index.htm

Journal

Journal of Systemic Therapies
www.guilford.com

Videos

See the Theory in Action Videos at Cengagebrain.com

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CHAPTER

14

Feminist and Multicultural Counseling and Psychotherapy

I've found that if I say what I am really thinking and feeling, people are more likely to say what they really think and feel. The conversation becomes a real conversation.

—Carol Gilligan

Lay of the Land

Rarely does anyone enjoy being stereotyped; it is never fair, accurate, or correct. Yet our brains are categorizing machines, designed to constantly separate out safe from not safe. This same mechanism that distinguishes a stick from a rattlesnake plays havoc in our social relationships and worlds. Thus, this chapter is likely to shake things up for you personally and with anyone with whom you discuss it. Raising issues such as gender, culture, race, ethnicity, and class involves stereotypes and often triggers painful moments of being ostracized, marginalized, or otherwise "less than." So, I encourage you to notice your response as you read this chapter and spend time reflecting on what comes up.

To get started, several schools of feminist and multicultural counseling have developed over the years (Worell & Johnson, 2001):

- *Liberal/reform feminisms:* Focusing on egalitarianism, liberal and reform feminists view sexism and oppression as irrational prejudices and sex role socialization; their focus is on increasing women's individual freedom, autonomy, self-fulfillment, dignity, and equality *within existing counseling and psychotherapeutic traditions.*
- *Radical/socialist feminisms:* Radical and socialist feminists view social oppression as the primary root of women's problems and therefore directly challenge patriarchy, male domination, and men's control over women's bodies. Their approach emphasizes increasing awareness of all forms of oppression, empowering women to make changes, and effecting social change.
- *Cultural/interpersonal feminisms:* Developing the popular relational-cultural and self-in-relation theories at the Stone Center, cultural feminists argue that women's experience is distinctly different from men's, constituting a unique and equally valid subculture that values relationship, cooperation, and emotionality.
- *Multicultural feminisms:* Addressing the unique needs of ethnic minority women in Western cultures, multicultural feminists attend to the various cultural contexts that impact these women's lives, including sexism within Western culture as well as their

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own ethnic culture. Furthermore, issues of power, status, and empowerment are different in collectivist versus individualistic cultures, creating distinct and highly complex conflicts for women of color.

- *Postmodern feminisms:* Postmodern feminists explore the construction of gender and its realities in social contexts and relationships, attending to the impact of dominant societal discourses (see "Narrative Approaches" in Chapter 13) on an individual's identity.

Feminist Counseling

In a Nutshell: The Least You Need to Know

Feminist counseling theories focus on how the effects of gender, cultural, heterosexual, and other stereotypes affect an individual's identity and relationships and how these lead to the types of problems for which a person seeks counseling. Informed by cultural theory, feminist approaches are based on the premise that *humans seek, grow through, and move toward connection with others* across the life span (Jordan, 1997, 2010; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). A sense of connection and community is fundamental to an individual's sense of well-being. *Disconnection*, then, is the root cause of most forms of emotional distress, and this becomes the focus of treatment. The counseling process is characterized by egalitarianism, empathy, and mutuality; the relationship is an authentic and human encounter for both client and counselor. Through this relationship, clients learn to engage in *growth-fostering relationships*, relationships that enhance both parties' sense of well-being. The counseling process also involves analyzing the effects of oppression and social power on the client and their impact on the presenting concern. The process of counseling increases clients' awareness of sociopolitical issues in individual lives and empowers clients to make meaningful change in their personal lives, relationships, and larger community.

The Juice: Significant Contributions to the Field

If there is one thing you remember from this chapter, it should be …

Growth-Fostering Relationships and the Five Good Things

Feminists maintain that humans are primarily *relational*, that they seek, growth through, and move toward connection with others (Jordan, 2010; Jordan et al., 1991). The desire for connection is the primary motivating force, in contrast to more traditional human development models that emphasize individuation. Feminists view the idea of a separate self as a myth that is based on a spatial metaphor of separateness, with psychodynamic theories generally positing that the more separate the self, the better it functions (Jordan, 2010). In contrast, feminists use a model of human development that recognizes the inherent interdependence of humans for survival, both physical and psychological (Comstock, 2005). Rather than a stage-based model of human development, feminists describe development as a complex, multifaceted process in which people increase their abilities to be differentiated *within* relationships and increase their capacity for *mutuality*.

However, all relationships are not created equal. The type of relationships that we seek, that are good for us, and that help us to grow are different from others because they allow us to fully experience and safely explore our sense of self. Relational-cultural counselors refer to these as *growth-fostering relationships*, which are characterized by the *five good things* (Miller & Stiver, 1997; Jordan, 2010).

- Increased zest and energy
- Increased sense of self-worth
- Increased knowledge and clarity about one's own experience, the other person, and the relationship
- Increased creativity and productivity
- Increased desire for more connection without feeling helpless or needy

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Feminist counselors build growth-fostering relationships with clients to (a) foster personal growth and (b) increase clients' capacity to authentically be in relationship outside of session. When assessing clients, feminist counselors listen carefully for growth-fostering relationships in clients' lives that are characterized by the five good things. Counselors help clients nurture the growth-fostering relationships that they already have, transform other relationships to be growth fostering, and/or develop new ones.

Rumor Has It: The People and Their Stories

Laura Brown A leading feminist practitioner and author, Laura Brown (1994, 2006, 2010) is a founding member of the Feminist Therapy Institute and has written extensively on feminist ethics, the politics of diagnosis, and surviving trauma.

Carolyn Zerbe Enns Carolyn Enns, an active feminist therapy theorist, focuses her work on integrating feminist and multicultural issues in everyday practice. In addition, her more recent research focuses on how to teach diversity sensitivity in the classroom (Enns, Sinacore, Ancis, & Phillips, 2004).

Carol Gilligan Carol Gilligan's *In a Different Voice: Psychological Theory and Women's Development* (1993) is a foundational feminist work that describes women's psychosocial and moral development organized around connectedness and interdependence based on an ethic of care, in contrast to traditional psychological theories based on masculine values of autonomy and individuation.

Judith Jordan A founding member of the Stone Center (see below), Judith Jordan is the director of the Jean Baker Miller Training Institute and is a leading figure in the development of relational-cultural theory (Jordan, 2010).

Jean Baker Miller A seminal theorist and founding member of the Stone Center (see below), Jean Baker Miller authored one of the first feminist books in the field, *Toward a New Psychology of Women* (1986), which clearly outlines a feminist alternative to the traditional understandings of the mind and relationships. Miller has been a principal figure in the development of self-in-relation and relational-cultural theories, exploring issues in practice, social action, and multiculturalism.

The Stone Center Feminists at the Stone Center at Wellesley College have been developing cutting-edge feminist theory for over 30 years. This implies that self-in-relation and relational theory are the same. But in other occurrences in this text, it implies that they are two different theories.

Big Picture: Overview of Counseling Process

The feminist counseling process evolved around two primary themes: (a) an egalitarian counseling relationship and (b) recognition of sources of oppression. The process of counseling involves the following:

1. *Developing an egalitarian relationship:* The initial goals of the counseling process are to develop (a) a relationship in which clients feel safe and understood and (b) a sense of having a voice in shaping the process.
2. *Exploring sources of marginalization and disconnection:* Next, the counselor works with the client to identify sources of relational disconnection and social marginalization that relate to and fuel the presenting problem.
3. *Fostering authenticity and empowerment:* Using the counseling relationship as a place to experience empathy and authenticity, counselors empower clients to transfer learning in session to address areas of concern in their everyday lives.
4. *Building better relationships and communities:* In the later stages of the counseling process, clients are encouraged to promote social change to reduce forms of oppression for themselves and others as a means of increasing their sense of being part of growth-fostering relationships and communities.

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Making Connection: Counseling Relationship

Egalitarian

Because social power is a central focus in feminist counseling, the counselor strives to make the counseling relationship *egalitarian* by closely attending to the inherent power imbalance in the relationship (Brown, 2010; Enns, 2004). How exactly do they achieve this seeming paradox? Feminist counselors have open discussions about the power dynamics and politics of counseling, such as the diagnosis process, communications with other professionals, and the counseling theories chosen. In these conversations, the counselor *demystifies* the counseling process and invites clients to share their opinions, ask questions, and do their own research, all of which is considered equally alongside the counselor's thoughts and theory (Worell & Remer, 1992). Much like in collaborative therapy (see Chapter 13), the feminist counseling process is a *mutual exploration* of how best to resolve clients' issues, in which counselors recognize clients' expertise in their own lives.

In addition, feminist counselors use *self-disclosure* to increase the sense of equality in the relationship and help clients develop hope and courage in their own lives. Counselors' egalitarian self-disclosure also involves admitting when they are wrong, being open to correction, and acknowledging personal defensiveness rather than assuming that relational disruptions are solely clients' faults. Instead, the counseling relationship is—in good times and bad—a two-way street where the counselor is equally responsible for bumpy roads and misunderstandings.

Mutual Empathy and Growth

A unique feminist concept, *mutual empathy* refers to two-way empathy in which each person—counselor and client—is able to see, know, and feel the inner experience of the other as well as experience *responsiveness* from the other. Mutual empathy involves *both persons impacting the other*, caring for the other, and responding to the other. This experience of mutuality repairs empathetic failures in early, formative childhood relationships, and recent research indicates that there is active brain resonance between people experiencing empathy and that this alters the functioning of the brain in positive ways (Schore, 1994). The counselor allows clients to see that what they say touches and moves the counselor in a personal and human way. These exchanges help clients feel more connected, reducing their sense of isolation from others and increasing their capacity for relationships that foster growth (see "Growth-Fostering Relationships and the Five Good Things" in "The Juice"). In addition, the counselor is authentically and personally touched in the process, enhancing the counselor's growth also.

Counseling relationships built on mutuality should not be misunderstood as sappy, saccharin-sweet relationships in which there is no conflict, disagreement, or confrontation. In fact, these relationships demand high levels of honesty and authenticity, which inherently bring differences and conflicts to the surface. However, because of the relational context, these differences can lead to "good conflict," in which each person's unique experiences, beliefs, and feelings are heard and *responded to*, allowing each member to learn and grow (Jordan, 2010). In good conflict, even though there is a difference, each person fundamentally feels safe and trusts that the relationship is not threatened. Thus, the counselor cannot retreat into a position of power but instead maintains an egalitarian, human presence and respectfully works through the differences with clients. In fact, moments of conflict and disconnection provide the most fertile opportunities for growth, for it is precisely in these moments when counselors can stay present and responsive and help clients have a *corrective relational experience*, enabling clients to develop new relational patterns (Jordan, 2010). Clients first learn to do this with the counselor and then transfer this to relationships outside the counseling process.

Authenticity

Feminist counselors cultivate *authenticity* in their relationships with clients. "Authenticity" in the counseling context does not mean that the counselor expresses just *any* old emotion, thought, or reaction that spontaneously arises but instead implies a genuine *responsiveness* that keeps the well-being and needs of the client in mind. Clinical judgment and ethics

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always guide the counselors' expressions of authenticity (Jordan, 2010). In determining which authentic expressions are appropriate with a given client, feminists ask themselves, "*Will this* [information, action, expression, etc.] *facilitate the client's growth? Will this further healing? Will this strengthen the relationship?*" Errors can occur, and when they do, the counselor needs to be ready to apologize and correct the relational disconnection, remaining responsive and open to hearing the client's response.

Feminist Code of Ethics

Feminists at the Feminist Therapy Institute (2000) have developed a *Feminist Code of Ethics*, which counselors use to guide their work and relationships with clients *in addition to* other professional codes. This ethical code describes a commitment to recognizing the impact of dominant cultural norms, acknowledging power differentials in relationships, managing overlapping relationships to avoid abuse, establishing counselor accountability, and promoting social change:

> Feminists believe the personal is political. Basic tenets of feminism include a belief in the equal worth of all human beings, a recognition that each individual's personal experiences and situations are reflective of and an influence on society's institutionalized attitudes and values, and a commitment to political and social change that equalizes power among people. Feminists are committed to recognizing and reducing the pervasive influences and insidious effects of oppressive societal attitudes and society. (p. 1)

Men and Feminist Counseling

Can men be feminist counselors? Do feminist counselors work with men? Yes and yes. Although many of the seminal ideas originate in feminist literature, the applications and values behind them are universal. Contemporary feminist approaches, such as relational-cultural therapy, emphasize diversity and relational responsiveness more than simply women's issues. The values that define feminist approaches—ending oppression, equality, and mutuality—have validity for men and women and have the potential to help both sexes live more authentically and with greater social connection.

Ironically, in the future, feminist approaches may have increased relevance for men. Twenty-first-century economic, political, and social changes are rapidly redefining the role of men in society, and men have had—as a group—more difficulty adapting to these changes than women had in the 20th century as their social roles were redefined (Rosin, 2010). For example, in 2010, for the first time, more American women worked than men. At the same time, 60% of college graduates were female. Many men are struggling to define themselves in a postindustrial economy, where flexibility, relationships, and collaboration matter more than physical strength and size. Additionally, male socialization pushes many men into disconnection from themselves and their emotions in boyhood, leaving them searching for ways to connect in adulthood (Shepherd, 2005). In the years ahead, feminist counselors may find they are surprisingly well equipped to help men struggling to find meaning, identity, and connection as their social roles are dramatically and rapidly redefined.

The Viewing: Case Conceptualization

The Personal Is Political; the Political Is Personal

One of the foundational assumptions of feminist counseling is that *the personal is political*, meaning that a person's internal reality—and therefore pathology—is inherently interconnected with political issues from the broader social context (Brown, 2006; Remer, 2008). This is true for men as well as women, heterosexuals as well as those with alternative sexual orientations, and persons of all cultural and ethnic backgrounds. The reverse is also true: the political is also personal (Brown, 2006), meaning that what happens at the societal level affects people in a very personal way. Thus, when developing a case conceptualization, feminist counselors help clients separate internal and external sources of problems by *raising awareness* of oppression, privilege, and societal impact on individual experience. For example, a professional Hispanic mother who is feeling depressed would be encouraged to look at the numerous and contradictory

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expectations society maintains for the roles of "mother" and "professional" as well as the American stereotypes of Hispanic women and the Hispanic community's expectations of her. Similarly, a working-class African American father struggling with substance abuse would be encouraged to examine social roles associated with his class, race, and gender in relation to his problems. In the case study at the end of this chapter, the counselor helps Jayla examine the political effects of being a professional African American woman in an emotionally abusive relationship, considering multiple, interlocking layers of marginalization.

The Politics of Diagnosis

Like other postmodernists, feminists have long challenged, as an oppressive practice, the diagnoses outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013). Far from over, this critique is more alive than ever:

> I would submit that feminist critiques of the diagnostic process exemplified by the *DSM* remain fresh and will be even more necessary in the future as increasing numbers of people receive one of these labels during the course of their lives. What does it mean that almost half of the U.S. population qualifies for a formal diagnosis, according to recent news reports? Feminist critique demands a complex analysis and synthesis of the emerging data about the biology of various forms of distress, on the one hand calling into question assumptions about the hard-wired, evolutionarily immutable nature of some phenomena, and on the other calling attention to the profound changes made to neuro-anatomy by exposure to traumatic stress. Feminist theory requires that we conceptualize our clients' distress/ [using] a range of factors that include the parameters of distress and dysfunction as currently subjectively experienced by our clients. (Brown, 2006, p. 19)

As you may have surmised, feminist counselors are in no rush to find a diagnostic label to slap on clients. Instead, they carefully develop a thoughtful case conceptualization that includes the impact of social norms, cultural differences, gender politics, trauma, and clients' subjective experience and understanding of their situations (Brown, 2010). Most feminists would agree that in some cases, a diagnostic label can be helpful and even liberating. For example, women who have been sexually abused often feel quite relieved to hear that flashbacks, nightmares, and hypervigilance are quite normal responses to trauma. In every case, feminist counselors are keenly aware of the political impact that diagnosis has in relationships (e.g., how friends, partners, and family see the person), in medical treatment (e.g., services and fees by insurance companies), and, most important, on how clients see and understand themselves.

Gender Roles

One of the primary areas of assessment, feminist counselors carefully explore clients' *gender role expectations* and how these relate to the presenting problem and clients' lives more broadly (Miler, 1986). Feminists note that "gender is commonly the first identity that people experience, coming before other identity markers such as culture, ethnicity, or social class, because gender, as a sex-derived social construct, is frequently the variable of greatest importance to the human world into which a child is born" (Brown, 2010, p. 52). Counselors explore how the client has internalized social messages about gender and how an individual's social class, cultural background, profession, and sexual orientation shape the clients' understanding of gender roles. For example, many women who report feeling depressed strongly maintain gendered expectations that women put the needs of others before their own, physically, emotionally, and professionally. Not surprisingly, the National Institute of Mental Health (2010) reports that women are more likely than men to be diagnosed with a major depressive disorder as well as any mental health disorder. The social pressure for women to be nice, not make waves, and care for others takes a personal toll and sets the stage for depression (Kaplan, 1991). Feminist counselors explore the interaction of gender role and the development of psychological distress.

Self-in-Relation

One of the original theories at the Stone Center, *self-in-relation* theory refers to an alternative model for conceptualizing women's development (Surrey, 1991). In contrast to

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traditional developmental theories, "self-in-relation involves the recognition that, for women, the primary experience of self is relational, that is, the self is organized and developed in the context of important relationships" (p. 52). Thus, rather than follow the Ericksonian developmental model that emphasizes autonomy, self-reliance, self-actualization, and other forms of separation, feminists describe women as developing their sense of self *in and through relationships*. Thus, when developing case conceptualizations with clients, the counselor views women's development through a relational lens, exploring the evolution and development of self through significant relationships in a woman's life.

Marginalization and Oppression

Contemporary feminist counselors have far more on their agenda than women's issues. They are aware that in addition to gender, people can be marginalized because of culture, race, sexual orientation, age, ability, economic class, religion, and numerous other factors. All of these contribute to a person feeling *disconnected* and marginalized from the dominant group, rejected for one's "otherness." Chronically having to hide parts of the self to be accepted leads to psychological symptoms and pathology (Jordan, 2010). Thus, feminist counselors consider *social oppression* and isolation to be the root cause of clients' problems (Brown, 2010). By identifying these sources of marginalization in the case conceptualization process, counselors identify where and how to help clients build the connections they need to live full, authentic lives.

Relational Images

Relational-cultural counselors assess clients' *relational images*, internal constructs, and expectations of relationship based on early life experience, and carefully trace how these affect present-day relationships (Jordan, 2010). People who experience chronic disconnection and relational trauma develop negative relational images that diminish their ability to fully participate in growth-fostering relationships and restrict their ability to experience authenticity. Such negative images are projected onto other relationships, repeating a painful life pattern. Thus, the case conceptualization process involves identifying these patterns, which are both verbally described and often reenacted in the counseling relationship. In particular, counselors pay attention to *controlling images* that result in *shame* and *disempowerment*, defining what is acceptable and who the client is. These controlling images are often experienced as immutable by clients, resulting in *internal oppression*, where the client rejects parts of the self, thus becoming disconnected from the self as well as others. The counseling relationship is used as a forum for clients to modify their relational images so that they can experience more satisfying relationships, referred to as *correctional relational experiences* (similar to *corrective emotional experiences* described in Chapter 3). In the case study at the end of this chapter, the counselor assesses Jayla's early relational images with her mother, who was the sole caretaker of her and her sister.

Relational Resilience and Courage

A critical quality for healing, *relational resilience* refers to the ability to move back into relationship following disconnection and empathetic failures, as well as the ability to ask for help when needed (Jordan, 2010). Counselors don't force or push clients to work through disconnections either in session or in their personal lives but instead create a context in which it is safe to do so, modeling that the well-being of the relationship has priority over making a point and being right. Developing relational resilience requires courage but not the form of heroic legend, which glorifies individual accomplishment and typically domination of another. Instead, *relational courage* is far quieter and scarier: it requires vulnerability and the willingness to open up to another. The counselor's role is to help "encourage" clients so that they are willing to take the risks that intimacy and relationship demand.

"Mattering" and Connection

When assessing, feminist counselors pay particular attention to the growth-fostering relationships and other contexts in which clients feel that they "matter," that they are valued

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and cherished by another (Jordan, 2010). This sense of "mattering" to someone—either in a personal relationship or in broader social communities—is considered vital to mental and relational health and well-being; recent research has shown that this is particularly important for persons diagnosed with severe mental illness (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2008). Counselors listen for both areas of strength—relationships where clients feel they matter to someone—and areas where a sense of connection needs to be built, and they use these to identify goals and build on strengths.

Disconnection Strategies and the Central Relational Paradox

In addition to identifying sources of connection, feminist counselors also identify the strategies clients use to disconnect from others when they feel vulnerable. Counselors use several questions to guide their assessment of disconnection:

Assessment of Disconnection

1. What strategies are used to disconnect from others: family, partner, friends, colleagues, children, and so on?
2. Where were these methods first learned and used?
3. Does shame or disempowerment fuel the need for disconnection?
4. How useful are these strategies in current relationships?
5. Does the client know how and when to reconnect?

Try It Yourself

Find a partner and use the above questions to assess how each person disconnects when relationships feel threatening.

One way that people cope with repeated disconnection is to alter the self to fit the wishes of others at the expense of personal authenticity; this is referred to as the *central relational paradox* because it describes how, in response to disconnection, a person seeks connection by avoiding authentic connection. This paradoxical attempt to connect without connecting must change in order for clients to experience growth-fostering relationships that promote wellness.

Targeting Change: Goal Setting

Sociopolitical Awareness and Empowerment

Feminist counselors strive to increase a person's *sociopolitical awareness* of how their individual identity is interconnected with one's broader place in society and *empower* clients to define themselves by alternative standards. Feminists strive to have all clients become more aware of how their *gender*, *ethnicity*, *social class*, *sexual orientation*, *physical characteristics*, and *physical abilities* significantly affect a person's identity and sense of self-worth (Worell & Johnson, 2001). Thus, one of the goals is to help clients develop greater awareness of how these sociocultural variables inform their identity, critically evaluate their effects, and ultimately develop their identity by crafting their sense of identity with full awareness, using personal values and the values from communities that have personal significance.

Connection

The overarching goal of feminist counseling, specifically relational-cultural counseling, is to build *connection*, specifically *growth-fostering relationships* (Jordan, 2010). When clients are able to establish such relationships, they create contexts in which they can authentically experience themselves while feeling a zest for life, valuing the self, being productive, and learning more about who they are: quite simply, a recipe for a lifelong process of evolving into one's best self.

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The Doing: Interventions

Introduction to Feminist Techniques

The emphasis of feminist counseling is on case conceptualization and the quality of the counseling relationship more so than on intervening. In fact, interventions from other approaches may be used *if adapted* in a gender and culturally sensitive manner (Enns, 1992; Worell & Remer, 1992). The techniques below are some of the unique ones used in feminist counseling.

Gender Role Analysis

A hallmark and defining intervention, *gender role analysis* involves encouraging clients to exam how cultural rules about male and female behavior affect the client's current distress, including multiple cultural rules from the different contexts of a client's life, such as religious, work, family, and ethnic traditions (Enns, 2000; Worell & Remer, 1992). Used with both men and women, gender role analysis helps clients better identify the often unacknowledged pressures and beliefs that support the problem. In the case study at the end of this chapter, the counselor helps Jayla increase her awareness of how her gender role interacts with being a professional and African American, and of her tolerance of inappropriate behavior from her boyfriend.

Questions to Facilitate Gender Role Analysis

- What beliefs do you have about being a "good woman" (or man) that might be related to the presenting problem?
- In what ways do you see gender stereotyping affecting you at work, at home, in your family, with friends, with your children, in your religious community, in your ethnic community, and so on?
- What did you learn from your parents about what it means to be a girl/boy or man/woman? Which of these still affect you today?
- What do you believe is a woman's (or man's) role in work? In a relationship? In a family? Regarding finances? Regarding health?
- What are your relationships like with men, women, heterosexuals, and persons who identify as gay/lesbian/bisexuals/transgendered?
- (If in a heterosexual relationship) How do you see gender roles playing out in your relationship? Do you like these effects?
- (If in same-sex relationship) How do you see gender stereotypes and gay/lesbian stereotypes playing out in your relationships?
- What is your philosophy on gender relations and cultural issues?
- How have gender, culture, sexual orientation, class, ability, and other diversity variables affected how you see yourself?

Try It Yourself

Find a partner and use the above questions to explore how gender roles affect the lives and relationships of each.

Assertiveness Training

Assertiveness training, a classic cognitive-behavioral technique, is adapted by feminists for helping empower clients, most notably women, who have been socialized to put the needs of others before their own (Worell & Remer, 1992). Assertiveness training involves teaching clients the difference between assertive, passive, and aggressive behaviors:

- *Assertive:* Able to balance the needs of self and others
- *Passive:* Attends only to the needs of others
- *Aggressive:* Attends only to the needs of self

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Using a psychoeducational approach, clients are taught in role-plays and real-world experiments how to advocate for their needs while honoring the needs of others in difficult interpersonal situations.

Self-Esteem Training

Proposed as an alternative to assertiveness training for women with very low self-esteem and/or constricted by rigid gender role stereotypes, self-esteem training emphasizes increasing a client's self-awareness and confidence, which ultimately enables her to assert her needs in interpersonal relationships (Stere, 1985). Self-esteem training involves developing four areas of personal skills:

1. *Accepting feelings as rational and valid:* Validating feelings of guilt and resentment related to sociocultural inequities; trusting feeling reactions; expressing feelings
2. *Being able to please self:* Knowing what one wants; feeling worthy; taking action and making requests on one's own behalf
3. *Identifying personal strengths:* Valuing feminine qualities; feeling courage to be successful; making positive self statements
4. *Being gentle with self and accepting personal "imperfections":* Developing realistic expectations for self; feeling calm when criticized; stating what shortcomings are

Corrective Relational Experiences

Relational-cultural theory describes how the mutuality of the counseling relationship provides numerous opportunities for *corrective relational experiences*, experiences in which old relational images are reworked by the counselor, providing an alternative, connecting response in a situation where the client had experienced only disconnect in other relationships (Jordan, 2010). For example, clients who had highly critical parents often experience extreme, painful disconnection with even the slightest negative comment. When counselors are able to stay connected and empathetic with clients who feel criticized or feel as if they have failed in some way, the counselor provides a *corrective relational experience* by not disengaging when clients have come to expect the other to abandon them. By maintaining an empathetic and mutually engaged relationship, counselors help clients work through various corrective relational experiences, first in session and ultimately in relationships outside of the counseling context. For example, in the case study at the end of this chapter, the counselor uses in-session corrective relational experiences to help Jayla learn how to relate to her boyfriend better.

Self-Empathy

Relational-cultural approaches emphasize the importance of developing *self-empathy* in clients, the ability to bring empathetic awareness and a gentle presence to one's own experience (Jordan, 2010). Rather than judging or rejecting, clients learn how to stay with their feelings and experience empathy for how they came about. Clients first experience empathy from without, from the counselor, but are then encouraged to use this same kind of empathy in their inner dialogues. Counselors promote self-empathy by questioning their negative self statements, such as "I shouldn't feel this way" or "I was a fool to do X." Such statements are countered with questions, such as "You are so accepting of others, but you do not accept the same qualities (actions, feelings, etc.) in yourself." If a client is particularly self-loathing, the counselor may ask the client to imagine it was a friend who was experiencing the situation and to have the client identify how she would see the situation in that case.

Social Activism and Social Justice

The feminist counseling is not a solitary process. Clients cannot meaningfully redefine their gender and personal identity stories or seek connection in a vacuum or even in the dyad of the counseling relationship. By definition, changing one's gender identity and building connection happens in relationship and community. Thus, for clients to change, their relationships and social connections must also change. One way this is commonly achieved is through *social activism* and *social justice work* of various forms, activities

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that clients often spontaneously seek in the closing phase of treatment. This can involve something as stereotypical as becoming involved in activist groups but more often takes far subtler forms, such as getting a group of mothers or fathers together from work or taking a stand on body issues in a circle of friends. Sometimes clients ask counselors where they can make a difference in the community with certain groups, such as children who have been sexually abused or immigrants needing assistance, and counselors should be ready and able to help them connect with appropriate community resources. Often, helping others who have experienced similar painful situations can be a transformative experience in which a client shifts from feeling like a victim to full recovery.

In addition, feminist counselors themselves are committed to social justice causes, using both professional and personal venues to effect societal change. This may take the form of advocating for clients in obtaining mental health or other services, in court situations, or in other contexts related to the client. Additionally, feminist counselors typically are involved in broader social movements, women's movements, clients' rights groups, children's advocacy, political campaigns, and similar efforts to promote social change.

Putting It All Together: Feminist Treatment Plan Case Conceptualization and Treatment Plan Templates

Theory-Specific Case Conceptualization: Feminist

Use the prompts below to develop a theory-specific case conceptualization; the case study at the end of the chapter provides an example.

- *Personal as Political/Political as Personal:* Describe how the client's presenting problem relates to broader political and social contexts and how the political affects the client's personal life.
- *Politics of Diagnosis:* Describe political and social considerations related to the client's DSM diagnosis.
- *Gender Roles:* Describe how gender role expectations are affecting the client related to the presenting problems.
- *Self-in-Relation:* Describe how significant relationships have shaped the client's sense of self.
- *Marginalization and Oppression:* Describe the ways the client may be experiencing a sense of marginalization and oppression. These experiences may be due to race, culture, gender, sexual/gender orientation, economic class, religion, ability, age, and so on. These experiences may vary from context to context: work, home, community, and others.
- *Relational Images:* Describe significant relational constructs and expectations based on early life relationships. In particular, are there controlling images that evoke shame or disempowerment?
- *Relational Resilience and Courage:* Is the client able to reconnect following disconnection and empathic failures in significant relationships?
- *"Mattering" and Connection:* Does the client feel as though he/she matters to significant others, and is there a sufficient sense of connection with others?
- *Disconnection Strategies and the Central Relational Paradox:* Describe strategies for disconnecting from others when feeling vulnerable. Is shame or disempowerment related to the pattern of disconnection? Does the client know how to safely reconnect?

Treatment Plan Template: Feminist

Use this treatment plan template for developing a plan for clients with depressive, anxious, or compulsive types of presenting problems. Depending on the specific client, presenting problem, and clinical context, the goals and interventions in this template may need to be modified only slightly or significantly; you are encouraged to significantly

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revise the plan as needed. For the plan to be useful, goals and techniques should be written to target specific beliefs, behaviors, and emotions that the client is experiencing. The more specific, the more useful it will be to you.

Treatment Plan

Initial Phase of Treatment

Initial Counseling Task

1. *Develop working counseling relationship. Diversity consideration:* [Describe how you will specifically adapt your approach to be sensitive to client diversity when developing the counseling relationship; this may include respecting cultured and gendered norms for emotional expression.]
   Relationship building intervention:
   a. Develop **growth-fostering relationship** using **mutual empathy** and authenticity.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Attend to relational and conflict management preferences based on gender, ethnicity, and other diversity factors.
   Assessment Strategies:
   a. Identify **gender role expectations** and the effects of the **political on the personal**, including sources of **marginalization** and **oppression**.
   b. Assess sources of "**mattering**," **relational resilience**, and **disconnection strategies**.

Initial Phase Client Goal

1. *Increase* **empowerment** and feelings of "**mattering**" to reduce [specific crisis symptoms].
   Interventions:
   a. Identify sources of **marginalization**, **oppression**, and **disconnection** that fuel sense of crisis.
   b. Identify **relationships and communities** that provide support and connection when needed to manage feelings that lead to crisis.

Working Phase of Treatment

Working Phase Counseling Task

1. *Monitor quality of the working alliance. Diversity consideration:* [Describe how you will attend to issues of power and client's sense of **empowerment** to provide honest feedback to counselor.]
   Assessment Intervention:
   a. Look for evidence of and ask about client experiencing **five good things** in counseling relationship; use Session Rating Scale.

Working Phase Client Goals

1. *Increase* awareness of the effects of **politics-as-personal**, **gender roles**, and **marginalization** to reduce [specific symptoms: depression, anxiety, etc.]. *Interventions:*
   a. **Gender role analysis** and analysis of **sociopolitical influences** and how they affect the problem.
   b. Connect with friends, groups, and causes that create a sense of **empowerment** in relation to the problem issue.

(*continued*)

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2. *Increase* ability to relate to people and situations from an assertive position of respect for self and others to reduce [specific symptoms: depression, anxiety, etc.].
   Interventions:
   a. **Assertiveness training** to learn how to balance asserting one's needs while respecting those of others.
   b. **Self-esteem training** to develop a greater sense of self-acceptance.
3. *Increase* number and quality of mutual growth-fostering relationships to reduce [specific symptoms: depression, anxiety, etc.].
   Interventions:
   a. **Corrective emotional experiences** to learn how to relate more authentically.
   b. Learn to identify **disconnection strategies** and ways to repair the disconnection.

Closing Phase of Treatment

Closing Phase Counseling Tasks

1. *Develop aftercare plan and maintain gains. Diversity consideration: [Describe how you will access resources in the communities of which they are a part to support them after treatment ends.]*
   Intervention:
   a. Identify **relational** and **sociopolitical** forces that are likely to generate problems in the future, and explore potential assertive responses.

Closing Phase Client Goals

1. *Increase* client's sense of **relational resilience**, "**mattering,**" **and empowerment** to reduce feelings of disconnection [or anxiety, fear, etc.]
   Interventions:
   a. Apply learning from corrective **emotional experiences** in session to relationships outside.
   b. Empower client to advocate for **relational resilience** and marginalized others in relationships.
2. *Increase* **advocacy** and **social justice** efforts for self and/or marginalized others to reduce sense of disempowerment [or depressive, anxious, compulsive behaviors, etc.].
   Interventions:
   a. Identify contexts and relationships for **advocacy efforts** that enhance client's sense of self-esteem.
   b. Identity relationships and organizations that foster client's ongoing **growth and resilience**.

Research and the Evidence Base

Similar to narrative and collaborative counseling, feminists have conducted relatively little empirical research on their specific approach; however, they draw from the common factors and attachment research to support their work (Brown, 2010). Similar to humanists, feminists cite the common factors evidence that indicates that a supportive, nonjudgmental counseling relationship is consistently correlated with positive outcomes to support their models that emphasize an egalitarian relationship (Brown, 2006). In addition, recent neurological research provides support for the premise that humans are "hard-wired" for relational connection and, in fact, that the human brain needs human relationship to develop and function properly (Jordan, 2010). These streams of research, although not on feminist theory directly, do support many of the core premises of the approach. Some research has been conducted on training counselors to become aware

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of feminism and power issues. For example, Keeling, Butler, Green, Kraus, and Palit (2010) demonstrated that the Gender Discourse in Therapy Questionnaire was effective in helping counselors better identify gender issues in counseling. More research needs to be conducted on the effectiveness of the feminist model as well as on training counselors working from all perspectives about how to identify gender issues in session.

Tapestry Weaving: Working with Diverse Populations

Cultural and Ethnic Diversity

Designed for addressing cultural and gender issues, feminist approaches are generally well suited for diverse populations. In addition to narrative (Chapter 13), the feminist counseling approach is one of the few mental health theories that places societal issues of oppression at the heart of treatment, and most feminist practitioners believe that advocacy and social justice in the general community is part of their roles as counselors (Brown, 2006). Feminists believe in equality in relationships, equality between the sexes, self-determination, and the primacy of relationships and connection. Although many clients also embrace these values, feminist counselors must remain aware that these are *not* shared by all people; some of these values potentially contradict certain traditional religious and cultural beliefs.

In fact, feminist approaches have been criticized because they potentially marginalize the experience of multicultural women by mistakenly assuming that the values of white, middle-class American women are universally applicable (Kallivayalil, 2008; Sharma, 2001). Thus, even though these approaches are designed to reduce oppression, because they include specific values, it is possible for clients to feel misunderstood if the approach is not adapted for their personal beliefs and values. In particular, some men feel immediately unsafe when they hear that their counselor identifies as a "feminist." Thus, feminist counselors should make extra efforts to develop solid, respectful relationships when working with clients who are likely to have different religious, political, and/or cultural beliefs and values.

South Asian American Women and Domestic Violence

Several counselors have addressed the implications of using feminist counseling and psychotherapy principles with Asian American women because traditional Asian cultures typically have strong patriarchal structures and traditions (Kallivayalil, 2008; Kawahara & Espin, 2007; Preisser, 1999; Shama, 2001; Yick, 2001). These issues are particularly poignant when working with Asian American women who are battered by their husbands, where very quickly the tensions arise between Asian patriarchal and collectivist values and American feminist and individualist ideals (Kallivayalil, 2008; Yick, 2001).

In a series of qualitative interviews with South Asian mental health practitioners working with South Asian American victims of domestic violence, Kallivayalil (2008) explored how these conflicts were addressed in counseling. First, the Asian American mental health practitioners tended to view the root of domestic violence in South Asian American communities as the rigid gender stereotypes and excessive patriarchy. Many reported the pressures of immigration seemed to reinforce these sexist social tendencies as well as create a new context for challenging them.

Additionally, these practitioners reported that clients needed intervention on multiple fronts: financial, educational, legal, relational, and psychological. When intervening, counselors explored the effects of their current community as well as communities in their native country, because both played important roles in how the women saw themselves and their life choices. Finally, the practitioners emphasized having *patience*. For many women, simply verbalizing their abuse experiences for the first time took weeks or months and was a difficult process. Making decisions about how to address safety and their needs took even longer. Most practitioners encouraged the women to consider the effects of the larger social context rather than blame themselves for their difficulties. Some reported taking a stronger stance to empower the women to make their own choices. When women

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decided to stay, the practitioners helped them find ways to safely redefine their roles in the family and to more effectively use the sources of power they did have.

Sexual Identity Diversity

Because of their careful attention to the experience of oppression and marginalization, feminist counseling methods have particular relevance for working with sexually diverse clients. Feminist counseling is designed to help clients address the negative effects of sexism, heterosexism, racism, and classism, all of which may affect clients who identify as gay, lesbian, bisexual, or transgendered. In particular, feminist counselors focus on how one's experience of gender intersects with sexual identity (Brown, 1994; Szymanski, 2005). The feminist approach to analyzing the complex interrelationship between the political, gender roles, and oppression, and the psychosocial and political effects on individuals, provides a powerful and typically liberating framework for understanding same-sex attraction or cross-gender identification.

Lesbian Internalized Heterosexism

Szymanski (2005) describes how feminist approaches can be used to address heterosexism with lesbian clients. Developing a positive identity as a lesbian requires recognizing and shifting internalized negative attitudes toward lesbianism, which are pervasive in the dominant culture. Szymanski (2005) encourages counselors to address the "personal is political" with lesbians to reduce their internalized heterosexism by doing the following:

- *Attend to the sociocultural context:* Counselors can assist lesbian clients in identifying sources of marginalization and oppression in their everyday lives by asking about experiences of "invisibility, rejection, prejudice, harassment, discrimination, and violence" (Szymanski, 2005, p. 79). Once these sources of oppression are identified, counselors can work with clients to decide how best to address these: by changing themselves (e.g., alter inner self-talk and beliefs), changing their environments (e.g., promote social change or simply leave), or both.
- *Identify and challenge internalized negative messages:* Counselors can help lesbian clients recognize both subtle and more obvious internalized negative beliefs about lesbianism. More subtle beliefs may include the assumption that lesbians hate men, cannot be feminine, or cannot be good parents. Additionally, many lesbians cope with these negative beliefs by seeking perfectionism in one area of life and/or having unrealistic fears that hold them back from pursuing particular actions (Szymanski, 2005). These coping strategies can be reduced by reducing the impact of the correlated negative beliefs.
- *Facilitating social change:* Feminist counselors encourage clients to pursue opportunities to promote social change. This may be achieved by raising awareness, pursuing policy changes, or creating support groups (Szymanski, 2005). Often, such activity has a healing and empowering effect for clients who experience marginalization.
- *Integrated analysis of oppression:* Finally, Szymanski (2005) suggests counselors use an integrated analysis of oppression, considering how all forms of oppression in clients' lives intersect and shape identity as well as presenting problems. For example, a lesbian survivor of sexual abuse may question the reality of her same-sex attraction due to the abuse, and a lesbian of color may experience multiple layers of oppression from the larger culture and her subculture(s). Counselors can help clients identify how these various negative messages intersect and compound their sense of isolation and disconnection.

Feminist Case Study

A 43-year-old African American corporate attorney, Jayla has come to counseling because she says that she believes her current relationship has eroded her self-esteem and she is feeling more and more depressed. She has been with Mark for over ten years

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and says that she feels lucky to be with a man who is not intimated by her successful career. Since she makes more than he does, she pays for many of their living expenses and their lavish vacations. She says they argue often because "I am not going to keep my mouth shut just to keep the peace; I am a lawyer after all." In their arguments, Mark often makes comments that question her competence and intelligence, and over the years Jayla believes she is beginning to believe him. He also tries to control what she wears, because he can be jealous and often puts down her choice of friends; she denies that he has ever hit or thrown things at her. She describes being raised by her mother, "who was an amazing woman of faith and strength"; she worked two jobs to raise her and her sister and ensured that both girls did well in school and stayed out of trouble. Her mother, who was the only parent she knew, died two years ago from breast cancer, and Jayla takes pride in trying to be strong in her memory. She and her sister remain very close and have helped each other through the loss of their mother. Jayla has no kids but wonders if it is not too late to change that.

Case Conceptualization: Feminist

This case conceptualization was developed by selecting key concepts from "The Viewing: Case Conceptualization" section of this chapter. You can use any of the concepts in that section to develop a case conceptualization for this or other cases.

The Personal Is Political; the Political Is Personal

As a successful African American woman, AF (adult female) is experiencing two forms of oppression in her relationship: stigma as a successful woman and as an African American woman. Her boyfriend is emotionally abusive, which in part may be triggered by his insecurity with their reversed roles, with her being the primary breadwinner. His need to control and be superior are likely informed by his socially reinforced definition of what it means to be a man.

The Politics of Diagnosis

Given that AF's situation is clearly related to gender and race politics, *DSM* diagnoses, which focus on individual pathology, are not the best explanation for her situation. Describing her situation in terms of the gender and race politics is more likely to help her successfully cope and manage.

Gender Roles

Gender role expectations are at the heart of AF's situation. She learned from a very independent model for being a woman and has flourished as a professional in a competitive field. In contrast, her boyfriend is using a more traditional definition of male-female roles in which the man has the right to make decisions about how a woman conducts herself. On the one hand, AF believes that she is asserting herself by standing up to him and arguing; on the other, she says that over the years she feels as though these arguments and constant questioning are causing her to slowly lose her confidence. She has begun to question herself more and more, leading to a sense of depression.

Self-in-Relation

AF reports developing a confident self-in-relation to her mother and sister, both of whom were/are strong, independent women who were/are supportive of her. Unfortunately, her current relationship with her boyfriend has increasingly not been a place where her true self feels safe and can flourish, and instead she feels she must fight to defend herself.

Marginalization and Oppression

Undoubtedly, AF has experienced numerous forms of marginalization and oppression as an African American woman in a highly competitive, male-dominated profession. These experiences are likely replicated in her current relationship. Her response has been to fight and stand up for herself in the face of oppression, but the negative comments still affect her self-esteem and confidence.

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Relational Images

Although AF's mother worked long hours, AF still reports feeling connected to her mother and her sister. These growth-fostering relationships still sustain her today and are informing her uneasiness with her current romantic relationship, where she is not feeling safe and supported.

Relational Resilience and Courage

AF has demonstrated relational resilience and courage in that she continues to work on her relationship with her boyfriend, even though she has not made significant progress. This tendency to try to work through the relationship may actually be keeping her stuck.

"Mattering" and Connection

AF feels less and less like she matters in her relationship with her boyfriend; however, she still feels a sense of connection and mattering with her sister.

Disconnection Strategies and the Central Relational Paradox

When feeling disconnected, AF tries to reconnect by debating the point with the other and trying to convince the other to see her perspective. Debating and arguing draws on her professional strengths but is not working to reestablish connection in her current relationship.

Treatment Plan: Feminist

Initial Phase of Treatment

Initial Phase Counseling Tasks

1. *Develop working counseling relationship. Diversity consideration:* Use a direct, open communication style; use language and provide information that is appropriate for client's level of education; attend to client's experiences of marginalization as African American woman.
   Relationship building intervention:
   a. Develop **growth-fostering relationship** with AF using **mutual empathy** and **authenticity**.
2. *Assess individual, systemic, and broader cultural dynamics. Diversity consideration:* Assess for three-generation system as well as for history of marginalization, generally and within professional contexts.
   a. Identify **gender role expectations** and the effects of the **political on the personal**, including sources of **marginalization** and **oppression** that relate to her gender, race, and professional position.
   b. Assess sources of "**mattering**," **relational resilience**, and **disconnection strategies** in current and past relationships.

Initial Phase Client Goal

1. *Increase* **empowerment** and feelings of "**mattering**" to reduce feelings of depression.
   a. Analyze sources of **marginalization**, **oppression**, and **disconnection** that fuel sense of crisis, namely, her current relationship and any similar professional dynamics.
   b. Identify **relationships and communities**, such as her sister, that provide support and connection when needed to manage feelings that lead to crisis.

(*continued*)

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Working Phase of Treatment

Working Phase Counseling Tasks

1. *Monitor quality of the working alliance. Diversity consideration:* Attend to issues of racial and educational power; assess client's sense of **empowerment** and ability to provide honest feedback to counselor.
   a. Monitor for evidence of and ask about client experiencing **five good things** in counseling relationship.

Working Phase Client Goals

1. *Increase* awareness of the effects of **politics-as-personal**, **gender roles**, and **marginalization** and how they play out in current relationship to reduce depression and increase self-esteem.
   a. **Gender role analysis** and analysis of **sociopolitical influences** in relationship and in career.
   b. Connect with friends, sister, religious groups, and causes that create a sense of **empowerment** as a successful African American woman.
2. *Increase* ability to relate to boyfriend from an assertive position of respect for self and other to reduce loss of confidence and self-esteem.
   a. **Assertiveness training** to learn how to balance asserting her needs while respecting those of her boyfriend.
   b. **Self-esteem training** to develop a greater sense of self-acceptance in the relationship and in professional settings.
3. *Increase* number and quality of mutual growth-fostering relationships to reduce loss of confidence.
   a. **Corrective emotional experiences** in session to learn how to relate more authentically.
   b. Learn to identify **disconnection strategies** used in relationship and find ways to repair the disconnection.

Closing Phase of Treatment

Closing Phase Counseling Tasks

1. *Develop aftercare plan and maintain gains. Diversity consideration:* Include African American community resources to support client after counseling ends.
   a. Identify **relational** and **sociopolitical** forces that are likely to generate problems in the future and consider potential assertive responses.

Closing Phase Client Goals

1. *Increase* client's sense of **relational resilience**, "**mattering**," **and empowerment** in intimate relationships to reduce feelings of inferiority and depression.
   a. Apply learning from corrective **emotional experiences** in session to romantic relationships.
   b. Empower client to advocate for **relational resilience** in relationships.
2. *Increase* **advocacy** and **social justice** efforts for self and marginalized others to reduce sense of disempowerment.
   a. Identify contexts and relationships for **advocacy efforts** that enhance other African American women's sense of self-esteem.
   b. Identity relationships and organizations that foster personal ongoing **growth and resilience**.

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Questions for Personal Reflection and Class Discussion

1. Describe a growth-fostering relationship in your life.
   - How did it affect you?
   - How was it created and sustained?
2. Do you agree that counselors should also grow in and through counseling relationships? Why or why not?
3. In what ways do you believe counseling relationships can be egalitarian? In which ways not?
4. Describe an example in your life of: the personal is political and the political is personal.
5. In what ways do you conform to gender roles and in which ways do you not?
6. Do you find the concept of self-in-relation theory a good description of how women develop their sense of self? Why or why not?
7. With whom did you develop the most significant relational images in your life? How have they affected you?
8. Do you think counselors are obligated to promote social justice in their communities? Why or why not?
   - What are the ethical implications of encouraging clients to be agents for social justice?
9. What are the strengths and potential problems for using feminist ideas with women from patriarchal cultures? What ethical concerns might arise?
10. Why do you believe most clients in counseling are women? What ethical implications does this have for counselors?

Online Resources

Associations

Feminist Therapy Institute
www.feminist-therapy-institute.org

Feminist Therapy Code of Ethics
www.feminist-therapy-institute.org/ethics.htm

Stone Center at Wellesley College
www.wellesley.edu/Counseling/index.html

Videos

See the Theory in Action Videos at Cengagebrain.com

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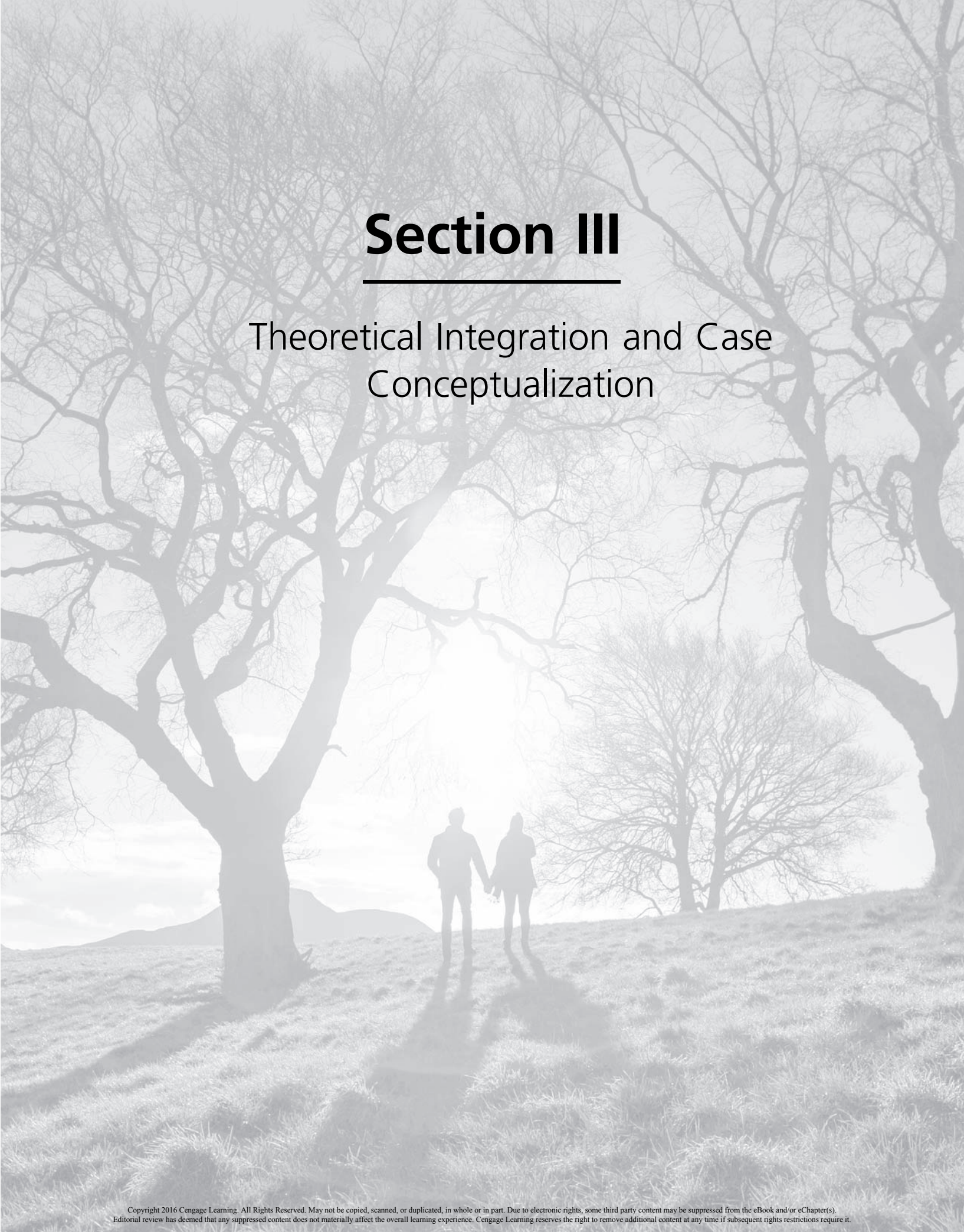

Section III

Theoretical Integration and Case Conceptualization

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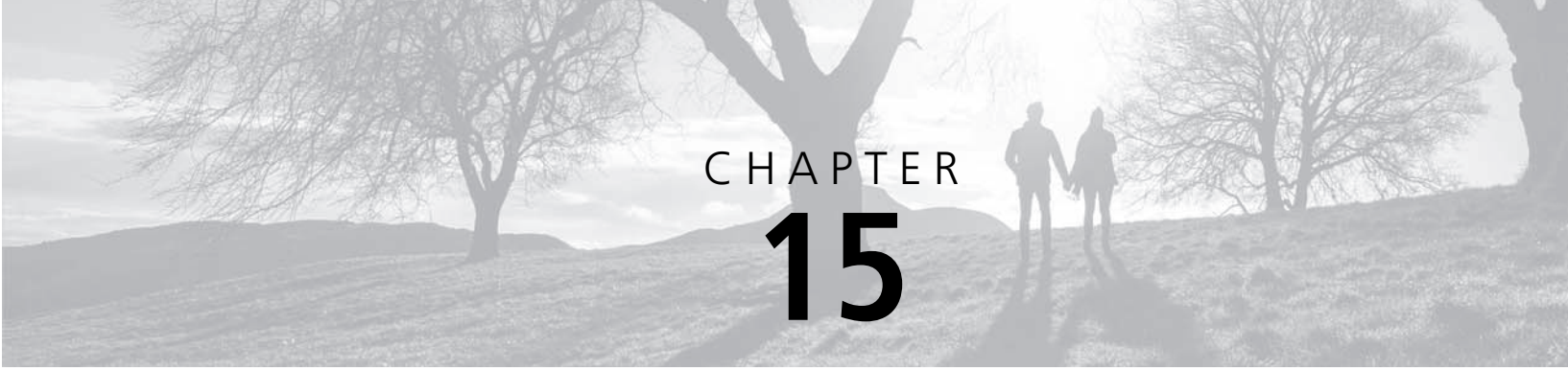

CHAPTER

15

Introduction to Theoretical Integration

And Now for the Exciting Conclusion

As you may (or may not) recall, in the cliffhanger in Chapter 1, I refused to tell you more about integration and eclecticism and instead encouraged you to read through Chapters 3 through 14 with a curious and open mind. Now that you are done with the grand tour of theories, you are probably still wondering, "Do I really have to choose?" The answer is, of course, a frustrating yes *and* no. To unravel the multiple layers of this question, let's begin exploring what integration and eclecticism entail in the daily work of counseling.

As discussed in Chapter 1, the common factors movement coincides with a more general movement in counseling and psychotherapy toward theoretical *integration* and *eclecticism* (Miller, Duncan, & Hubble, 1997). Just as it sounds, "integration" refers to combining two or more theories into a coherent approach, while "eclecticism" implies a process of borrowing from more than one theory. At first, integration and eclecticism sound like you can have your cake and eat it, too—almost too good to be true. Well, it's not that simple.

Doing integration or eclecticism poorly is easy enough. However, doing it well is far more challenging. It's like putting together a gourmet meal at a salad bar. It's possible; you have all of the right ingredients. But you are more likely to put together a hodge-podge of a meal that is unpleasant for your dinner companions to look at and leaves you feeling bloated. In fact, it takes a trained and restrained person with chef-like instincts to create something of value from the rich and diverse offerings of a salad bar. Similarly, it takes more effort and discipline to do integrative therapy well than it does to work from a single approach, which has been put together and field-tested for you by a gourmet of the psychotherapy world. Thus, choosing to work from a single theory is more like eating at a five-star restaurant: the menu is shorter, but you can be sure that everything on it will be excellent. At the salad bar, you need to put a lot more thought and energy into creating an equal rival. Thus, I generally do not recommend that new counselors start with an integrative or eclectic approach because it is far more difficult to do well. That said, as new counselors become more skilled and experienced, they are likely to move in the direction of integration.

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Integration Options

The term "integration" is used a lot in the field, but rarely it seems that folks are using the same definition. This perhaps accounts for why there is so much debate. So the next time you find yourself arguing with a colleague about "integration," you might just want to clarify which variety of integration is being discussed:

- Common factors
- Theoretical integration
- Assimilative integration
- Technical integration
- Systematic treatment selection
- Syncretism and sloppy thinking

Common Factors Approach

As described in Chapter 1, counselors who use the *common factors approach* for integration conceptualize treatment using a common factors model, which identifies the core ingredients of counseling models, such as counseling alliance, client resources, and hope. Counselors who use this approach can then integrate concepts from various approaches using the common factors model. For example, a counselor may use the core conditions from person-centered counseling (see Chapter 6) to build the counseling relationship and solution-generating questions from solution-focused counseling (see Chapter 12) to generate hope. These practices are then incorporated and coherently connected using the common factors theory.

Theoretical Integration

As the name implies, counselors who use *theoretical integration* combine two or more theories into a single coherent theoretical model with the intention of improving or expanding the potentials of either alone. Most evidence-based treatments (manualized treatments for a specific population; vaguely remember Chapter 1) are examples of theoretical integration. Emotionally focused therapy is an example of how systems theory, humanistic theory, and attachment theory have been combined to treat couples with better-than-average results (Johnson, 2004). Similarly, the now well-established cognitive-behavioral approaches (see Chapter 9) are an example of integrating behavioral and cognitive theories. Furthermore, many of the family counseling and therapy approaches are also examples of theoretical integration. Early pioneers, such as Virginia Satir (1972) and Carl Whitaker (Whitaker & Keith, 1981), integrated humanistic-existential and systemic approaches to develop their unique family models. In addition to these more formalized integrative models, individual clinicians also develop their unique integrative approaches, which are distinguished from technical eclecticism (see below), by the clear and thought-out combining of two or more theories.

Assimilative Integration

Closely related to theoretical integration, "assimilative integration" refers to having a firm theoretical grounding in one approach while selectively integrating practices from other approaches, to allow for a broader range of intervention possibilities (Norcross & Beutler, 2008). In this approach, for example, a counselor may integrate solution-based scaling into a humanistic approach to identify goals and progress. After years of practice, the vast majority of counselors who identify with a single school of counseling most likely also practice some form of assimilative integration.

Technical Eclecticism

Counselors using *technical eclecticism* draw freely from techniques of various theories without significant concern about the theoretical underpinnings. Instead, the primary

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focus is identifying interventions that are likely to work for a specific client with a specific concern (Norcross & Beutler, 2008). Eclectics put little emphasis on the philosophical and theoretical principles underlying a technique and instead focus on trying to achieve desired outcomes from a specific theory. Increasingly, counselors are able to include evidence-based practice (using a literature review of research studies to identify potential treatments; see Chapter 1) to more precisely inform the choice of treatment.

Systematic Treatment Selection

Systematic treatment selection models, such as Norcross and Beutler's (2008), provide an organized template for integrating theories that incorporates evidence-based practice (see Chapter 1). These approaches are designed to identify appropriate treatments and therapeutic relationships for a specific client. In Norcross and Beutler's approach, they (a) use evidence-based practices to identify what the research has shown to be an effective treatment for a particular client or problem, (b) draw from multiple systems of counseling to address client issues, (c) use five diagnostic and nondiagnostic dimensions to develop a case conceptualization, and (d) adapt treatment methods *and* the counseling relationship to best meet client needs. The five areas used to develop a case conceptualization include the following:

- *Mental health diagnosis:* The client is diagnosed using standard medical diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000).
- *Stages of change:* The client's readiness for change is described in one of four stages: contemplation, preparation, action, or maintenance.
- *Coping style:* The client's coping style is generally described as *internalizing* (e.g., depressed, self-critical, inhibited) or *externalizing* (e.g., aggressive, impulsive, stimulation-seeking).
- *Resistance level:* A client's resistance level refers to his or her willingness to take direct intervention from the counselor; if the client's resistance level is low, the counselor can use more directive techniques, whereas if the client's resistance is high, nondirective and paradoxical interventions are more appropriate.
- *Patient preferences:* Finally, the counselor considers client's preferences for the type of relationship and treatment; this often serves to accommodate diversity issues as well as the interaction of diversity issues between counselor and client (e.g., gender differences, age differences, ethnicity differences, educational differences).

Syncretism and Sloppy Thinking

As you might imagine, it is quite possible—or even likely—to use the labels "integration" or "eclectic" to simply mask a haphazard approach of doing what you feel like when you feel like it, without much understanding of what you are doing or why or if there is any scientific or theoretical reason to do it (i.e., "bad therapy"). Norcross and Beutler (2008) refer to this as *syncretism*, which simply refers to combining various philosophies. The result can take the form ranging from a less-than-optimal approach to an outright lawyers-will-be-involved, harmful approach.

Too often, counselors develop pet theories or techniques because they have not received proper training, often unaware of what is being missed. Unfortunately, this is increasingly common, because intensive post-degree training in specific treatment approaches or areas of specialty is less common in the United States due to the increasing costs and the drop in reimbursement rates over the years. Perhaps the best way to ensure you don't slip into sloppy, syncretic thinking is to seek intensive training in at least one approach. In addition, understanding philosophical differences between schools of counseling will also help prevent the mass confusion that leads to less-than-effective forms of syncretism.

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Integration with Integrity

The key to integrating with integrity is understanding the difference between *philosophy* and *theory*. Each theoretical model is built on basic philosophical assumptions, such as what counts as "truth," what counts as "real," what it means to be human, and how humans change. Each theoretical model defines certain practices based on these assumptions. In most cases, skillful integration involves grounding yourself clearly in *one* set of philosophical assumptions and then *integrating* practices from other models and modifying them as necessary to *fit largely within a single set of philosophical principles*.

When counselors fail to work from a single, consistent set of philosophical assumptions, their clients are likely to become confused. For example, if one week the counselor focuses on emotional expression (based on the assumption that clients' internal, subjective reality is the focus of treatment), then the next week focuses on observable behaviors (based on the assumption that treatment should focus on externally validated behavior), and then later moves to an exploration of multiple, contradictory realities (based on the view that reality is constructed), the client is likely to be as confused as a first-semester counseling student taking a comprehensive theory exam without reading the textbook. In contrast, if counselors ground their approach in a single philosophical approach, such as humanistic, they can then draw on techniques from diverse phenomenological models—person-centered, Gestalt, and existential—and techniques from other models to support the general phenomenological process, such as analyzing a person's defense mechanisms (psychodynamic therapy) or schemas (cognitive therapy) to identify how these mechanisms impede the client's process of self-actualization.

Overview of Philosophical Schools

	Modernist	Phenomenological	Systemic	Postmodern
Truth	Objective truth	Subjective truth	Contextual truth	Multiple, coexisting truths
Reality	Objective; observable	Subjective; individually accessible	Contextual; emerges through systemic interactions; no one person has unilateral control	Co-constructed through language and social interaction; occurs at individual, relational, societal levels
Counseling relationship	Expert; hierarchical	Empathetic other	Participant in counseling system	Nonexpert; co-constructor of meaning
Counselor's role in change process	Teaching and guiding clients in better ways of being, interacting	Creating context that supports natural self-actualization process	"Perturb" system, allowing system to reorganize itself; no direct control of system	Facilitate a dialogue in which client constructs new meanings and interpretations
Associated schools	Psychodynamic; cognitive-behavioral	Person-centered; existential; Gestalt; Adler	Systemic	Solution-focused; narrative; collaborative; feminist; multicultural

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Modernism

Modernism is founded on logical-positivist assumptions of an external, knowable "truth." In modernist approaches, the counselor assumes a role as expert, as is common in cognitive-behavioral and traditional psychodynamic therapies. The work of counselors who ground their approach in modernist philosophy are generally characterized by the following:

Common Modernist Assumptions

- The counselor is an expert who assumes the primary responsibility for identifying pathology, problems, and goals, often assuming the role of teacher or mentor.
- The counselor uses theory and research as the primary source of identifying problems and diagnosing.
- The counselor uses theory and research to select treatment approaches; clients are expected to adapt to selected treatment.

Although broadly grounded in modernistic assumptions about knowledge, traditional psychodynamic and cognitive-behavioral theories have their own unique stance on the primary source of truth, the means through which it is best identified, and how best to define the counseling relationship.

	Psychodynamic	Cognitive-Behavioral Therapies
Primary source of objective truth	Counselor's analysis of client dynamics based on theory	Measurable, external variables
Truth identified through ….	"Reality check"; comparing client experience against external perceptions, events, etc.	Scientific experimentation; counselor definition of "reality" and/or social norms (identified through research)
Counseling relationship	Hierarchical; counselor indirectly leads client toward goals	Educator; counselor straightforward in directing client toward goals

Phenomenology: Humanistic-Existential

Phenomenological therapies are founded on a philosophy that prioritizes the individual's subjective truth and include Carl Rogers's (1951) person-centered therapy, Fritz Perls's Gestalt therapy (Parsons, 1975), and existential therapy (Frankl, 1963). In addition, although Adler's theory is generally considered a "dynamic" theory, its *philosophical foundations* are best classified as a phenomenological approach because the operating assumptions are closer to the humanistic-existential approaches (Sweeney, 2009); this an excellent example of why understanding the philosophical assumptions is critical to understanding the theory.

Most phenomenological theories share the following assumptions:

Common Phenomenological Assumptions

- All people naturally tend toward growth and strive for self-actualization, a process of becoming authentically human.
- The primary focus of treatment is the subjective, internal world of clients.
- Counseling interventions target emotions with the goal of promoting catharsis, the release of repressed emotions.
- A supportive, nurturing environment promotes counseling change.

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Although based on similar philosophical traditions, person-centered, Gestalt, existential, and Adlerian approaches have different styles and assumptions, including differences related to the preferred ways to address self-actualization, change, confrontation, and counselor use-of-self.

	Person-Centered	Gestalt	Existential	Adler
Self-actualization best promoted through ….	Emotionally safe and nurturing environment	Counselor being "fully human"; warmth and confrontational	Directing reflection on existential issues, such as death, alienation, etc.	Social interest and relational connection
Change promoted through ….	Nondirective, process-oriented reflections	Affective confrontation of phony layers of self	Encouraging exploration of existential anxiety, fear of death, loss, etc.	Psychoeducation; tasks; challenging private logic
Style of confrontation	Gentle, supportive	Direct and harsh when needed to break through denial	Intellectual; stark; "reality" focused	Educational direction
"Authentic" use of self-of-counselor defined as ….	Genuine caring for the client	Showing full range of human emotions within counseling relationship	Acknowledging shared human experiences	Encouragement; egalitarian relationship

Systemic

Rather than a formal philosophical school, systemic therapies are grounded in *general systems theory*, which highlights that living systems are open systems, connected with and embedded within other systems (von Bertalanffy, 1968), and *cybernetic systems theory*, which emphasizes a system's ability to self-correct in order to maintain homeostasis (Bateson, 1972), the latter being more influential in development of specific counseling models, such as the brief therapy approach of the Mental Research Institute (MRI) (Watzlawick, Weakland, & Fisch, 1974), strategic therapy (Haley, 1976; Madanes, 1981), and the Milan team's systemic approach (Boscolo, Cecchin, Hoffman, & Penn, 1987). Systems theories emphasize *contextual* truth, truth generated through repeated interpersonal interactions that set a norm and rules for behavior. General tenets shared by systemic counselors are the following:

Common Systemic Assumptions

- One cannot *not* communicate; all behavior is a form of communication.
- An individual's behavior and symptoms always make sense in the person's broader relational contexts.
- All behaviors, including unwanted symptoms, serve a purpose within the system, allowing the system to maintain or regain its homeostasis or feeling of "normalcy."

(*continued*)

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- No one individual unilaterally controls behavior in a system; thus, no one person can be blamed for problems in a couple or family relationship. Instead, problematic behavior is viewed as emerging from the interaction patterns between members of the system.
- Counseling change involves alternating the interaction patterns within the system.

Within the field of systemic family therapy, Bateson's (1972) distinction between *first-order* and *second-order cybernetics* had a significant impact on how counselors worked with families. *First-order cybernetics* refers to describing systemic functioning as if the counselor is an objective, neutral observer describing the family as a detached outsider. *Second-order cybernetic* theory applies the rules of first-order cybernetics on itself, positing that the counselor cannot be an objective, outside observer but instead creates a new system with the family: the observer-observed or counselor-family system. This second-order system is subject to the same dynamics as the first, including the drive to maintain homeostasis and rules for relating that are mutually reinforced. Second-order cybernetic theory maintains that whatever the counselor observes in the family reveals more about the *counselor's* values and priorities than the family's, because any description exposes what the counselor pays attention to and what the counselor ignores or misses. Second-order cybernetics laid the foundation for transition to postmodern therapy, specifically constructivism in the MRI and Milan schools (Watzlawick, 1984).

In general, in all systems counselors are influenced by both first- and second-order cybernetic theory. In practice, counselors will generally emphasize one level of systems analysis or another. Broadly speaking, strategic therapy worked more at the first-order approach, with the MRI and Milan approaches gravitating toward second-order and later constructivist approaches:

First-order cybernetic approaches lean toward the modernist tendency to find a more objective form of truth. Counselors who practice systemic therapies using a first-order orientation use more assessment instruments of family functioning and rely heavily on the counselor's perception of the system to guide practice.

Second-order cybernetic approaches lean more toward a postmodern approach to truth (see below). Their focus is on how the counselor and client co-construct a second-order system, which has its own unique set of rules for establishing truth.

	First-Order Cybernetics	Second-Order Cybernetics
Level(s) of analysis	Family system	Family system (level 1) and counselor-family system (level 2)
Interventions target	Correcting interactional sequences	"Perturbing" or interrupting interactional sequences
Counselor role	Tends to appear as a knowledgeable expert	Co-creator of counseling system
Assessment focuses on ….	Behavioral sequences	Meaning-making systems (epistemology)

Postmodern

Postmodern therapies are based on the premise that objective truth can never be fully known because it must always pass through a person's subjective and intersubjective filters, which always affects what is seen. Postmodern counselors share several common assumptions:

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Common Postmodern Assumptions

- The human mind does not have access to an outside reality independent of human interpretation; objectivity is not humanly possible.
- All knowledge and truth is culturally, historically, and relationally bound and therefore intersubjective, constructed between people.
- What a person experiences as "real" and believes to be "true" is shaped primarily through language and relationships.
- Language and the words used to describe one's experiences significantly affect how one's identity is shaped and experienced.
- The identification of a "problem" is a social process that occurs through language both at the immediate local level and at the broader societal level.
- Therapy is a process of co-constructing new realities related to the client's personal identity and relationship with the problem.

Within counseling, there are three philosophical schools of postmodernism that are particularly influential (Anderson, 1997; Hoffman, 2002; Watzlawick, 1984):

- *Constructivism:* Constructivists focus on the construction of meaning within the individual organism, thus focusing on how information is received and interpreted.
- *Social constructionism:* Social constructionists focus on how people co-create meaning in relationships. They emphasize how truth is generated at the local (immediate) relational level.
- *Structuralism/poststructuralism:* Structuralists and poststructuralists focus on the analysis of how meanings are produced and reproduced within a culture through various practices and discourses.

Postmodern Philosophical Schools

	Constructivism	Social Constructionism	Structuralism/ Poststructuralism
Level of reality construction	Individual organism	Local relationship	Societal, political
Associated theories	Later MRI and Milan theories; contemporary Gestalt*; contemporary cognitive-behavioral therapy*	Collaborative therapy; reflecting teams; relational and intersubjectivity theories*	Narrative therapy; feminist and culturally informed therapies
Focus of interventions	Recasting interpretations with new language	Dialogues that highlight multiple meanings and interpretations	Deconstruction and questioning of dominant discourses (popular knowledge)
Counselor role	Facilitate alternative interpretations	Noninterventive; facilitate dialogical process	Help identify social and historical influences

*Several contemporary versions of Gestalt, cognitive-behavioral, and psychodynamic relational and intersubjectivity theories actually have strong postmodern elements.

Try It Yourself

Find a partner and rank the above four philosophical schools of counseling. Which do you like the most? Which do you like the least? What elements of your personal history or personality might account for your preferences?

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Wrapping Up Integration

Hopefully, you now know that skillfully using an integrative approach is not a carefree cop-out for someone who doesn't want to feel "tied down" to any one theory. To be done well, it requires *more skill* and *more discipline* than using a single theoretical model, especially if you are going to be able to answer questions about the evidence base to support your work. That said, it should not automatically be avoided and is perhaps an appropriate long-term goal for your professional development, especially if it helps address unique client needs. Similar to cooking, when starting out, it is generally easiest to begin by following tried-and-true recipes than it is to forge out on your own to create a new fusion of flavors. By trying to implement a single model at first, you develop a certain set of skills. Once that is mastered, you can determine what else might be useful to enhance that skill set and slowly build up a repertoire that works for you and those you serve.

Questions for Personal Reflection and Class Discussion

1. Which integration options were you most attracted to? Why?
2. Are you attracted to a particular theory or set of theories? Why do you think you are drawn to these?
3. Which philosophical school are you most attracted to?
   - What life experiences might account for your interest in these theories?
   - What personality traits might account for this?
4. Which philosophical school are you least attracted to?
   a. What life experiences might account for your lesser interest in these theories?
   b. What personality traits might account for this?
5. How might you go about learning more about specific theories?

Online Resources

Associations

Center for Clinical Excellence: Common Factors
www.centerforclinicalexcellence.com

Heart and Soul of Change
http://heartandsoulofchange.com

Society for the Exploration of Psychotherapy Integration
www.cyberpsych.org/sepi

Systematic Treatment Selection
www.systematictreatmentselction.com

Transtheoretical Model
www.uri.edu/research/cprc

Videos

See the Theory in Action Videos at Cengagebrain.com

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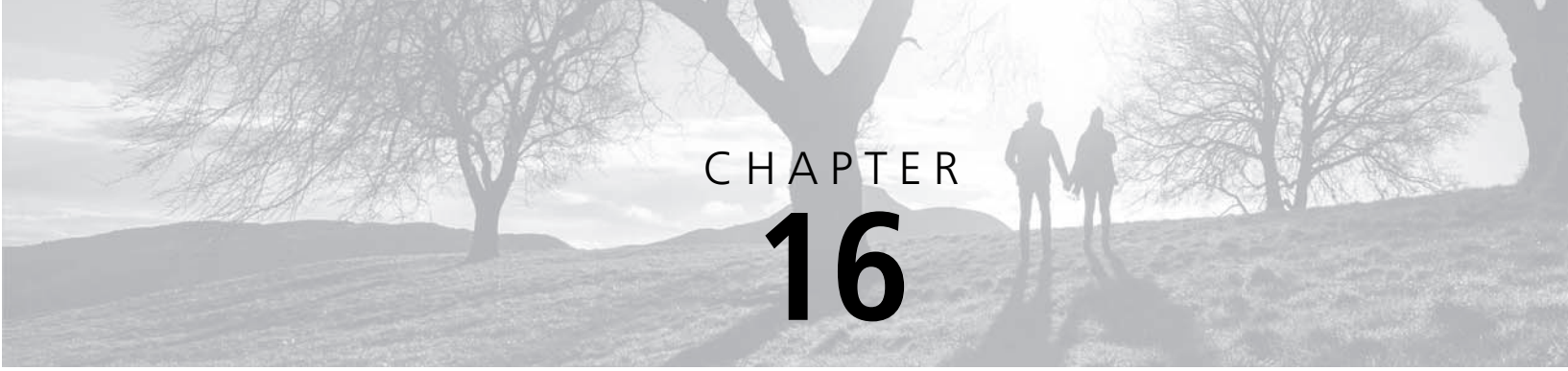

CHAPTER

16

Integrative Case Conceptualization

Case Conceptualization and Great Counseling

As already discussed, one thing (besides the hourly fee) separates a great counselor from a friend, bartender, or hairdresser: what each does with the information that is shared by clients. After hearing a heartfelt story of struggle, friends, bartenders, and hairdressers tend to do one of two things: give advice or offer sympathy. Counselors and therapists do something very different. They use what they have heard to develop a deeper understanding of clients, often a more sensible and compassionate story than clients tell themselves. When counselors listen to clients, they take the information that they are hearing to develop a map of the person's experience and inner world. This map is called case conceptualization, and it is the key to skillful, competent counseling. In fact, it is the primary reason we need counseling theories at all: once you have a clear conceptualization of what is going on, "what to do" is generally plainly evident. Thus, if you can develop a clear and meaningful case conceptualization, the counseling journey is relatively quick and smooth. If you miss the boat with this first step, you won't get very far.

Counseling theories provide counselors with unique lenses through which they may view the problems that clients bring to them. Much like a detailed map, theories allow counselors to view clients and their problems in a broader and more comprehensive context. This broad view allows counselors to see how the pieces fit together in a client's life and provides clues as to the best path out of a sticky situation. In each of the earlier theory chapters (Chapters 3 through 14), you read about case conceptualization using a single model. In this chapter, you will learn about a comprehensive case conceptualization approach that helps you consider a single case from multiple theoretical perspectives, which is ideal for learning about each theory and the interconnections across theories, and it also provides an excellent tool for thinking more broadly about cases.

Realistic Expectations

After forming a strong working relationship with clients, case conceptualization is the second-most important skill in counseling. However—and I will tell this to you without high-calorie sugarcoating—case conceptualization is the hardest skill to learn. In short, a comprehensive, integrative case conceptualization requires that you understand and apply most of what is in this book. That said, case conceptualization is also the most empowering and liberating counseling competency—because once you can do this,

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you will know how to handle almost every situation. So, roll up your sleeves and get ready for intense work.

In most cases, the first time you complete the case conceptualization in this text, it will take ten or more hours over the course of a week (this is one assignment you cannot cram for the night before it is due unless you live on a planet that spins more slowly than the earth). However, each time you do another one, you will find that you can complete it more quickly and easily because you are learning how to integrate and use the theoretical concepts. By doing this once, you learn what to listen for and ask about in session with clients (or pay attention to in a video or vignette, if doing this for a class assignment). The next time you do it, you begin to better understand how the dynamics in one section correlate with dynamics in another. After you do ten to twenty of these, your ability to conceptualize will significantly increase your counseling abilities both in in-session interventions and in out-of-session communications with your supervisor and other professionals.

Elements of Case Conceptualization

As counselors become more experienced, case conceptualization takes place primarily in their heads—while clients are talking. It happens so fast that often they have a hard time tracing their steps. However, new counselors need to take things more slowly. Similar to learning a new dance step, the new move needs to be broken down into small pieces with specific instructions for where the hands and feet go; with practice, the dancer is able to put the pieces together more quickly and smoothly until it becomes "natural" to him or her. That is what we are going to do here with case conceptualization. So, let's start with identifying the components of a counseling case conceptualization for working with an individual (a similar format of case conceptualization for working with couples and families is presented in the related text, *Mastering Competencies in Family Therapy*):

1. *Introduction of client:* Define who the client is (individual, couple, or family) and identify most salient demographics (e.g., age, ethnicity, language, job, grade in school, and such).
2. *Presenting concern:* Specify how all parties involved are defining the problem: client, family, friends, school, work, legal system, society, and so on.
3. *Background information:* Summarize recent changes, including precipitating events and related historical background.
4. *Strengths and diversity:* Identify personal, relational, and spiritual strengths, as well as resources and limitations related to diversity issues.
5. *Theoretical case conceptualization(s):* Use one or more of the following to develop an initial theoretical understanding of the client's personal and relational dynamics:
    - *Psychodynamic/Adlerian conceptualization:* Includes defense mechanisms, object relation patterns, Erickson's psychosocial development stages, and Adlerian style of life and basic mistakes
    - *Humanistic-existential conceptualization:* Expression of authentic self, existential analysis, and Gestalt contact boundary disturbances
    - *Cognitive-behavioral conceptualization:* Behavioral baseline, A-B-C analysis, and schema analysis
    - *Family systemic:* Family life cycle stage, boundaries, triangles, hierarchy, complementarity, and intergenerational patterns
    - *Solution-based and cultural discourse conceptualization:* Previous solution, unique outcomes, miracle question, dominant discourses, identity narratives, and preferred discourses

Alternatively, you can use the "The Viewing: Case Conceptualization" section of your preferred theory to develop a shorter, theory-specific case conceptualization for

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your client. The complete form for case conceptualization is at the end of this chapter and is also available on the publisher's and book's websites (www.cengage.com and www.masteringcompetencies.com). Below you will find basic instructions for completing each section; you will find the concepts in the "Theoretical Conceptualization" sections described in more depth in the corresponding theory chapter later in this book.

Examples of how to complete a case conceptualization are found at the end of each of the theoretical chapters of this text.

Introduction to Client

I. Introduction to Client

Identify primary client and significant others

Client

Age: _____ Select Ethnicity Select Relational Status
Occupation/Grade: _____ Other: _____

Significant Others

Select Person Age: _____ Select Ethnicity Select Relational Status
Occupation/Grade: _____ Other: _____

Select Person Age: _____ Select Ethnicity Select Relational Status
Occupation/Grade: _____ Other: _____

Select Person Age: _____ Select Ethnicity Select Relational Status
Occupation/Grade: _____ Other: _____

Select Person Age: _____ Select Ethnicity Select Relational Status
Occupation/Grade: _____ Other: _____

Others: _____

Case conceptualization starts by identifying the most salient client demographic features that relate to treatment. Furthermore, to more fully conceptualize treatment, it is best to also identify the significant others in the client's life, including partners, children, and/or parents. Common demographic information for the client and significant others includes the following:

- Gender
- Age
- Ethnicity and race
- Relational status and sexual orientation
- Current occupation/work status or grade in school
- Other salient identifying information, such as living situation, extracurricular activities, or immigration status is important to include.

This initial introduction provides the reader with a basic sketch of the client and his/her support network that will be elaborated on as the case conceptualization unfolds. As much as possible, include useful details that reveal a person's strengths, interests, and background, such as an adult's specific profession, the family's immigration status, or a child's extracurricular activities. Knowing whether someone is an artist, accountant, or aerospace engineer is useful clinical information; similarly, child counseling is generally

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facilitated by working with activities and metaphors from their interests in sports, art, music, and such.

To protect client information while enabling supervisors to easily track who is who, I typically use the following symbols in my notes; if there is more than one, I add the age after the abbreviation (e.g., CF7):

AF = adult female	CF = child female
AM = adult male	CM = child male

Presenting Concern

II. Presenting Concern(s)

Client Description of Problem(s): _____

_____

_____

Significant Other/Family Description(s) of Problems: _____

_____

_____

Broader System Problem Descriptions: Description of problem from referring party, teachers, relatives, legal system, etc.:

Name: _____

Name: _____

Often, new and even experienced counselors assume that the "presenting concern" is a straightforward and clear-cut matter. Once in a while it is, but most of the time it is surprisingly complex. Anderson and Goolishian (Anderson, 1997; Anderson & Gehart, 2007) developed a unique means of conceptualizing the presenting problem in their collaborative language systems approach, also referred to as collaborative therapy (see Chapter 13). This postmodern approach maintains that each person who is talking about the problem is part of the *problem-generating system*, the set of relationships that generated the perspective or idea that there is a problem. Each person who is talking about the problem has a different definition of the problem; sometimes the difference is slight and sometimes stark. For example, when parents bring a child to counseling, the mother, father, siblings, grandparents, teachers, school counselors, doctors, and friends have different ideas as to what the problem *really* is. The mother may think it is a medical problem, such as attention-deficit/hyperactivity disorder (ADHD); the father may believe it is related to his wife's permissiveness; the teacher may say it is poor parenting; and the child may think there really is not a problem at all.

Historically, counselors move rapidly to define the problem in a way that fits with their theoretical worldview: either a formal diagnosis (ADHD, depression, etc.) or another mental health category (such as parenting style, defense mechanism, family dynamics, etc.), with little reflection on the contradictory opinions and descriptions of the problem by the various people involved. Having a single problem definition helps focus the treatment. However, if adhered to too rigidly, having a single problem definition can quickly become a liability rather than an asset. The more a counselor can remain open to the alternative descriptions of the problem, the more maneuverability,

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adaptability, and creativity can be infused in treatment. In addition, remaining cognizant of the variability of understanding throughout treatment allows the counselor to maintain stronger rapport with each person involved, because each person's perspective is honored and referred to throughout the treatment. A description of the presenting problem should include the following:

1. The reason(s) each client states he or she is seeking counseling or has been referred
2. Any information from the referring agent (teacher, doctor, psychiatrist, etc.) and his or her description of the problem
3. A brief history of the problem and family (if applicable)
4. Descriptions of the attempted solutions and the outcome of these attempts
5. Perspectives from significant persons and institutions in the client's broader social network, including professional associates, religious organizations, close friends, and so on

Background Information

III. Background Information

Trauma/Abuse History (recent and past): _____

_____

Substance Use/Abuse (current and past; self, family of origin, significant others): _____

_____

_____

Precipitating Events (recent life changes, first symptoms, stressors, etc.): _____

_____

_____

Related Historical Background (family history, related issues, previous counseling, etc.): _____

_____

_____

Obtaining background information about the problem is the next step. Traditionally, counselors include information such as the following:

- History of childhood and adulthood abuse and trauma, including childhood abuse, rape, domestic violence, natural disasters, war, witnessing violence, and so on
- History of substance abuse by client, client's family, and significant others
- Precipitating events that are associated with the onset of the problem, such as recent life changes, breakups, losses, developmental milestones, career moves, and so on
- Related historical background, including history of mental disorders, previous counseling, significant health concerns, and so on

Often, this background information is considered the "facts" of the case. However, as counselors have historically cautioned, how we "language" the facts makes all the

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difference (Anderson, 1997; O'Hanlon & Weiner-Davis, 1989; Watzlawick, Weakland, & Fisch, 1974). For example, whether you begin by saying that the client "recently won a state-level academic decathlon," or you begin with "her mother recently divorced her alcoholic father," you are painting two very different pictures of the same client—for both you and anyone else who reads the assessment. Therefore, although this may seem like the "factual" part of the report where you as a professional are not imposing your bias, in fact, you impose bias by the subtle choice of words, ordering of information, and emphasis on particular details.

Based on research about the importance of the counseling relationship and of hope (Lambert & Ogles, 2004; Miller, Duncan, & Hubble, 1997), I recommend that counselors write the background section in such a way that the counselor and anyone reading the report, including, potentially, the client, would have a positive impression of and hope for the client—because these two factors have an effect on the outcome of treatment.

Assessment of Strengths and Diversity

Everything up to this point has been an introduction that provides a context and framework for understanding the actual assessment elements of the case conceptualization. In the following areas of assessment, counselors assess their clients using theoretical constructs from the major counseling theories in order to paint a multidimensional picture of clients and their life situation.

Client Strengths

IV. Client Strengths and Diversity

Client Strengths

Personal: _____

_____

Relational/Social: _____

_____

Spiritual: _____

_____

Diversity: Resources and Limitations

Identify potential resources and limitations available to clients based on their age, gender, sexual orientation, cultural background, socioeconomic status, religion, regional community, language, family background, family configuration, abilities, and so on.

Unique Resources: _____

Potential Limitations: _____

Client strengths and resources should be the first things assessed. This is a lesson I learned the hard way. When I began teaching case conceptualization, I put the client strength section at the end because it is more clearly associated with solution-based and postmodern approaches (see Chapters 13 and 14; Anderson, 1997; de Shazer, 1988;

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White & Epston, 1990), which were developed later historically. What I discovered is that after reading about the presenting problem, history, and problematic family dynamics, I was often feeling quite hopeless about the case. However, often, on reading the strengths section at the end, I would immediately perk up and find myself having hope, deep respect, and even excitement about the clients and their future. I have since decided to *start* by assessing strengths, and I believe it puts the counselor in a more resourceful mind-set.

Emerging research supports the importance of identifying client strengths and resources. Researchers who developed the *common factors model* (as you may remember from Chapter 1; Lambert & Ogles, 2004; Miller et al., 1997) estimate that 40% of outcome variance can be attributed to client factors such as severity of symptoms, access to resources, support system, and so on; the remaining factors include the quality of the counseling relationship (30%), counseling interventions and treatment models (15%), and the client's sense of hope (15%). Counselors can leverage client factors best by assessing for resources. Furthermore, assessing for strengths also strengthens the counseling relationship (30%) and can be done in such a way as to instill hope (15%), thus drawing on three of the four common factors. The potential impact of assessing strengths is hard to overestimate.

To conceptualize a full spectrum of client strengths and resources, counselors can include strengths at several levels:

- Personal/individual strengths
- Relational/social strengths and resources
- Spiritual resources

In addition, it is useful to identify specific resources and limitations due to diversity factors such as ethnicity, religion, spirituality, gender, socioeconomic class, ability, and so forth.

Personal/Individual Strengths

When assessing for personal/individual strengths and resources, you can begin by reviewing two general categories of strengths: abilities and personal qualities.

- *Abilities:* Where and how are clients functioning in daily life? How do they get to session? Are they able to maintain a job, a hobby, or a relationship? Are there any special talents, either now or in the past? If you look, you will always find a wide range of abilities with even the most "dysfunctional" of clients, especially if you consider the past as well as the present and future.

  Naming the abilities can increase clients' sense of hope and confidence to address the problem at hand. I find this especially helpful with children. If a child is having academic problems at school, the family, teachers, and child may not notice how the child is excelling in an extracurricular activity, such as karate, soccer, or piano. Often, noticing these areas of accomplishment makes it easier for all involved to find hope for improving the situation.

  Identifying the abilities may give clients or counselors creative ideas about how to solve a current problem. For example, I worked with a recovering alcoholic who hated the idea of writing but spoke often of how music inspired her. By drawing on this strength, we developed the idea of creating a special "sobriety mix" of favorite songs to help maintain sobriety and prevent relapse, an activity that had deep significance and inspiration for her.
- *Personal qualities:* Another area where counselors can identify client strengths is personal qualities. Ironically, the best place to find these is embedded within the presenting problem or complaint. Usually, the thing that brings them to see a counselor is the flip side of another strength. For example, if a person complains about worrying a lot, that person is equally likely to be a diligent and productive worker. Persons who argue with a spouse or child are more likely to speak up for themselves and are generally invested in the relationship in which they are arguing.

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In virtually all cases, the knife cuts both ways: each liability contains within it a strength in another context. Conversely, a strength in one context is often a problem in another. Here is a list of common problems and the strengths that may be found in clients with the presenting problems.

Problem	Possible Associated "Shadow Strengths"
Depression	• Awareness of what others think and feel • Connected to others and/or desires connection • Has dreams and hopes • Has had the courage to take action to realize dreams • Realistic assessment of self/others (according to recent research; Seligman, 2002)
Anxiety	• Pays attention to details • Desires to perform well • Careful and thoughtful about actions • Able to plan for future and anticipate potential obstacles
Arguing	• Stands up for self and/or beliefs • Fights injustice • Wants the relationship to work • Has hope for better things for others/self
Anger	• In touch with feelings and thoughts • Stands up against injustice • Believes in fairness • Able to sense one's boundaries and when they are crossed
Overwhelmed	• Concerned about others' needs • Thoughtful • Able to see the big picture • Sets goals and pursues them

As you can see, identifying strengths relies heavily on the counselor's viewing skills. A skilled counselor is able to "see" the strengths that are the flip side of the presenting problem, while remaining aware of the problem tendencies that are the inverse of a particular strength.

Relational/Social Strengths and Resources

- *Social support network:* Family, friends, professionals, teachers, coworkers, bosses, neighbors, church members, salespeople, and numerous others in a person's life can be part of a network of social support that helps the client in physical, emotional, and spiritual ways.
  - *Physical forms of support* include people who may help with running errands, picking up the children, or doing tasks around the house.
  - *Emotional support* may take the form of listening or helping resolve relational problems.
  - *Community support* includes friendships and acceptance provided by any community, and it is almost always there in some form with a person who may be feeling marginalized because of culture, sexual orientation, language, religion, or similar factors. These communities are critical for coping with the inherent stress of marginalization.

Simply naming, recognizing, and appreciating that there is support can immediately increase a client's sense of hope and reduce feelings of loneliness.

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Spiritual Resources

- *Spiritual:* Counselors are increasing their awareness of how clients' spiritual resources can be used to address the problems they bring to counseling (Morgan, 2006; Sperry, 2001; Walsh, 2003). Counselors should become familiar with the major religious traditions in their community, such as Protestantism, Catholicism, Judaism, Islam, New Age religions, Native American practices, and others as needed.

Drawing on the epistemological foundations of Bateson (1972, 2002) and more recent postmodern philosophies (Gergen, 1999), I have developed a definition of spirituality that I find particularly helpful for work as a counselor:

Spirituality: How a person conceptualizes his or her relationship to the universe or God (or however he or she constructs that which is larger than the self). In short, how a person relates to life (in the largest sense of the word).

Using this definition, everyone has some form of spirituality, which ultimately relates to how a person believes the universe operates. The rules of "how life should go" inevitably inform (a) what the person perceives to be a problem, (b) how a person feels about it, and (c) what that person believes can "realistically" be done about it, all of which a counselor wants to know about in order to help develop an effective treatment plan.

Questions to Assess Spirituality

A counselor can use some of the following questions to assess a client's spirituality, whether traditional or nontraditional:

- Do you believe there is a God or some form of intelligence that organizes the universe? If so, what types of things does that being/force have control over?
- If there is not a God, by what rules does the universe operate? Why do things happen? Or is life entirely random?
- What is the purpose and/or meaning of human existence? How does this inform how a person should approach life?
- Is there any reason to be kind to others? To oneself?
- What is the ideal versus realistic way to approach life?
- Why do "bad" things happen to "good" people?
- Do you believe things happen for a reason? If so, what reason?
- Does the person belong to a religious community or spiritual circle of friends that provides spiritual support, inspiration, and/or guidance in some way?

With the answers to these questions, counselors can create a map of the client's world that can then be used to develop conversations and interventions that are deeply meaningful and a good "fit" for the client. An accurate understanding of a client's "map of the life" reveals what logic and actions will motivate the client to make changes, thus providing counselors with invaluable resources for changes. For example, I have often found that many clients from traditional religious backgrounds and also more New Age groups believe that "things happen for a reason." I have had numerous clients use this one belief to radically and quickly transform how they feel, think, and respond to difficult situations.

Try It Yourself

Find a partner and take turns learning about each other's strengths in each area. What questions were most useful?

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Diversity

Related to strengths, diversity issues refer to characteristics such as age, gender, sexual orientation, cultural background, immigration status, socioeconomic status, religion, regional community, language, family background, family configuration, and ability. Much like strengths and symptoms, in most cases, each form of diversity brings with it both unique resources and limitations. For many, traumatic and oppressive experiences related to being a minority or simply "different" are at the core of their problematic situation, if not an exacerbating factor. Some counseling theories, such as feminist theory, narrative, and collaborative, consider these at the heart of the case conceptualization process (see Chapters 13 and 14). But in all cases, counselors need to take time to think about how the client's situation is affected by limitations created by diversity issues, such as living in poverty or being an immigrant, and consider these when conceptualizing the client's situation. As silly as it may sound to new counselors, it is *very* easy to not adjust the conceptualization assessment on the basis of theory. For example, how does one adjust what a secure attachment looks like in a Japanese versus an Italian family? What happens when you consider generations of immigration and socioeconomic status? What is normal then? Quickly, things become murky.

Furthermore, in most cases, each limitation that arises from being different has a correlating resource. For example, gays and lesbians are marginalized in numerous ways in our society and are often targeted for abuse, resulting in various levels of trauma; these experiences add significantly to their overall level of psychological stress. However, because of this marginalization, they tend to develop unusually strong social and friendship networks that help them to not only cope but also thrive. Similarly, many cultural and ethnic groups are marginalized in dominant society, but they also tend to have stronger-than-average social and religious networks that provide them a sense of belonging and support.

Theoretical Conceptualizations

The remainder of this form includes five potential areas of conceptualization using the major schools of theory covered in this book:

- Psychodynamic/Adlerian
- Humanistic-existential
- Cognitive-behavioral
- Family systemic
- Postmodern and feminist

Using one or more these allows for a slightly more integrative approach. Alternatively, you can use the "The Viewing: Case Conceptualization" section of a single theory to develop a theory-specific conceptualization.

Psychodynamic and Adlerian Conceptualization

V. Psychodynamic Conceptualization

Psychodynamic Defense Mechanisms *Check and describe the 2–4 most commonly used defense mechanisms*

❑ Acting Out: *Describe:* _____

❑ Denial: *Describe:* _____

❑ Displacement: *Describe:* _____

❑ Help-rejecting complaining: *Describe:* _____

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❑ Humor: *Describe:* _____

❑ Passive Aggression: *Describe:* _____

❑ Projection: *Describe:* _____

❑ Projective Identification: *Describe:* _____

❑ Rationalization: *Describe:* _____

❑ Reaction Formation: *Describe:* _____

❑ Repression: *Describe:* _____

❑ Splitting: *Describe:* _____

❑ Sublimation: *Describe:* _____

❑ Suppression: *Describe:* _____

❑ Other: _____

Psychodynamic Defense Mechanisms

Psychodynamic defense mechanisms refer to automatic psychological processes that a person uses to ward off anxiety and external stressors and thus describe strategies the person frequently uses to handle problems. A person may be conscious or unconscious about using a defense mechanism; generally, the more aware one is of using a defense mechanism, the more functional he or she is. In addition, certain defense mechanisms are considered more functional than others. For example, humor, sublimation, and suppression are considered more functional than mechanisms that require image distortion or disavowal, such as idealization, denial, and projection.

Originally described in early psychoanalytic writing, these defense mechanisms are widely recognized by counselors practicing from a variety of theoretical perspectives. An assessment of *defensive functioning* has been recommended for inclusion in the next edition of the *Diagnostic and Statistical Manual of Mental Disorders*, and a comprehensive list is included in the present edition (American Psychiatric Association, 2000). The current recommendation is to identify up to seven defense mechanisms that the client uses in session or describes using outside of session.

The purpose of identifying defense mechanisms is to better understand the client's internal dynamics, particularly those that are contributing to the presenting problem. That said, not all defenses are bad, and, in fact, they can be quite helpful at times. For example, at the beginning of Chapter 2, I share how my career in writing began as a type of sublimation. Similarly, I encourage new counselors to master the art of suppression: putting difficult ideas out of one's mind. Sublimation is an important skill that enables counselors to continue to focus on their clients during work hours, even when they are dealing with difficult matters in their personal lives (disappointing side note: life still happens to professional counselors and therapists). Thus, you should carefully reflect on what defense mechanisms your clients use, considering how they may be helpful in certain contexts.

The more common defense mechanisms are listed below; additional defense mechanisms are listed in the appendices of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision).

Acting Out

A common term that has trickled into the vernacular, the technical meaning of acting out as a defense mechanism refers to dealing with inner emotional conflict through action rather than reflecting on feelings. These actions may or may not translate to "bad behavior" but rather to a pattern of engaging in a behavior (e.g., physically fighting, starting verbal fights) to deal with inner conflict.

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Denial

One of the more famous defense mechanisms ("Denial is not just a river in Egypt") and one of the more difficult to assess initially (because your client probably won't mention it), denial refers to refusing to acknowledge a painful reality that is readily apparent to others. Denial is commonly seen in families with substance and alcohol abuse and in people with dead-end jobs and relationships.

Displacement

Most frequently observed in family dynamics, displacement refers to transferring feelings about one person (or situation) to another, less threatening substitute object. For example, if a person is angry at a spouse but afraid to raise the issue, it is usually easier to displace this anger onto one's young children, with whom that person is more likely to win an argument.

Help-Rejecting Complaining

Commonly observed in counseling sessions, help-rejecting complaining is just like it sounds: a person deals with stress by complaining but invariably rejects suggestions, advice, or help that others offer. I'd offer an example here, but I am confident you just came up with five examples from your personal list of friends, family, and acquaintances.

Humor

All joking aside, humor can be used as a defense mechanism whereby a person manages emotional conflict by identifying the amusing or ironic qualities of the situation. Humor can be used in a highly adaptive way, and it can also be used so rigidly that it almost becomes a form of denial.

Passive Aggression

Another of the more frequently cited defense mechanisms, passive aggression refers to when a person portrays a facade of cooperation but then covertly resists, resents, or undermines, thus indirectly expressing aggression. Sometimes this is easy to detect, as in a classic case of "backstabbing," and other times it is more subtle, such as endless procrastination or "forgetting."

Projection

Projection refers to falsely attributing one's own unacceptable feelings, impulses, or wishes onto another, typically without being aware of what is going on. In clinical practice, this is often seen in the case where one partner has cheated and then projects these intentions onto the faithful partner; this can happen whether or not the infidelity has been discovered.

Projective Identification

Projective identification takes simple projection to a whole new level. Similar to simple projection, projective identification involves falsely attributing to another one's own unacceptable feelings. However, in this case, the person is aware of having the unacceptable feelings but inappropriately justifies them by claiming that they are reasonable reactions to the other person, which often results in the other person acting in such a way as to confirm the projection, making it difficult to clarify who did what to whom first. The classic example of this is jealousy: a person is jealous of his partner's relationship with other men but claims that is because of her behavior. His jealousy causes her to be more secretive to avoid conflict, which further confirms his hypothesis about her, quickly creating a negative, downward spiral.

Rationalization

A favorite of the educated, rationalization refers to dealing with emotional conflict by concealing true motivations, by developing elaborate reassuring but incorrect explanations for thoughts, feelings, and emotions. For example, a person may offer intricate

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and convoluted explanations for excessive drinking behavior, staying in a bad relationship, or failing to take needed action.

Reaction Formation

Often linked with repression, reaction formation refers to dealing with difficult inner conflict by engaging in actions that are diametrically opposed to denied thoughts, feelings, and behaviors. A frequent example of this is someone who becomes a rigid religious adherent to cope with unacceptable sexual or materialistic desires; often this backfires, and the person makes headlines when they are caught in a sex or financial scandal.

Repression

More pathological than suppression, repression refers to eliminating unacceptable desires, thoughts, or experiences from conscious awareness, to the extent that the person is unaware of the inner conflict. Often the repression is used to describe how traumatized persons will sometimes repress memories associated with an event as a means of coping; the memory may later be triggered by another event, conversation, or other reminder.

Splitting

A term from object relations theory, splitting refers to the inability to see an individual—self included—as having both positive and negative qualities. Instead, the person swings from seeing people as all-good or all-bad: idealizing or villainizing. In some cases, they can rapidly alternate between an all-good or an all-bad view of the same person, creating significant chaos in relationships.

Sublimation

One of the more functional defenses, sublimation refers to dealing with internal conflict by channeling potentially inappropriate feelings or impulses into socially acceptable activities, such as challenging aggression through sports or sadness through art. This defense can be developed to help people find creative ways to use difficult emotions, such as sadness, anger, rage, fear, and so on.

Suppression

Unlike repression, suppression is the *intentional* avoidance of difficult inner thoughts, feelings, and desires. When thoughtfully chosen, this defense can be very useful when facing difficult emotions over extended periods of time, such as grief, complicated loss, and so on.

Object Relations and Attachment Patterns

Describe relationship with early caregivers in past: _____

_____

_____

Was the attachment with the mother (or equivalent) primarily: ❑ Generally Secure ❑ Anxious and Clingy ❑ Avoidant and Emotionally Distant ❑ Other: _____

Was the attachment with the father (or equivalent) primarily: ❑ Generally Secure ❑ Anxious and Clingy ❑ Avoidant and Emotionally Distant ❑ Other: _____

Describe present relationship with these caregivers: _____

_____

Describe relational patterns with partner and other current relationships: _____

_____

_____

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Object Relations and Attachment Patterns

Object relations theorists examine the client's relationship with early caregivers to understand the dynamics that are creating current difficulties (Bowlby, 1988; Johnson, 2004; St. Clair, 2000). In general, these patterns can be described in three ways:

- *Secure:* Client feels safe in relationships, is comfortable with intimacy, and does not have unreasonable fears of abandonment or losing self in a relationship. Generally, people with secure relationships seek counseling in response to a specific trauma or event.
- *Anxious:* Client unnecessarily worries about abandonment or rejection, often displaying jealousy and feeling insecure with the slightest criticism (or even without significant praise). The anxiety that such a person experiences in relationships frequently brings him or her to counseling for help.
- *Avoidant:* Clients with avoidant relational patterns often fear being swallowed or lost in a relationship and therefore remain emotionally unavailable and distant to help them preserve a sense of self.

These early childhood patterns typically repeat like variations on a theme in adulthood, both with the primary caregiver and in other relationships. By tracing these patterns, counselors can help clients more quickly identify core dynamic patterns that are affecting all areas of life.

Erickson's Psychosocial Developmental Stage

Describe development at each stage up to current stage

Trust versus Mistrust (Infant stage): _____

Autonomy versus Shame and Doubt (Toddler stage): _____

Initiative versus Guilt (Preschool age): _____

Industry versus Inferiority (School age): _____

Identity versus Role Confusion (Adolescence): _____

Intimacy versus Isolation (Young adulthood): _____

Generativity versus Stagnation (Adulthood): _____

Integrity versus Despair (Late adulthood): _____

Erickson's Psychosocial Developmental Stages

Erickson's eight stages of psychosocial development are one of the more useful developmental theories in applied clinical counseling. These stages provide a template for understanding the larger developmental concerns that may be underlying the problems clients bring to session. When viewed through a developmental lens, client problems often make more sense, and typically this insight informs more resourceful direction for counseling. For example, if a middle-aged man presents with depressive symptoms, examining these symptoms in the context of the struggle for generativity versus stagnation can help focus counseling on the deeper underlying issues that may be fueling the depression. In this case, rather than simply trying to relieve symptoms, the focus of counseling can be to help him achieve a sense of purpose and contribution.

Chapman (2006) explains that the developmental challenge at each stage of development is to achieve an effective *ratio* between the two counterbalancing dispositions, such as trust and mistrust, rather than maximize one at the expense of the other. Ideally, a person will develop a tendency toward trust yet also know when it is appropriate to distrust; having blind trust in everyone and everything is not adaptive. Thus, a person strives to find a healthy balance between the two propensities at each stage. Development issues

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arise when a person develops an extreme tendency toward one of the two dispositions, such as being overly trusting *or* overly distrustful. When one tends toward the first, more positive-sounding disposition, this is referred to as a maladaptation; if one tends toward the second, this is referred to as a malignancy. Chapman's (2006) table summarizes:

Trust versus Mistrust: Infant Stage

Maladaptation (overemphasize trust): Unrealistic, spoiled, deluded
Malignancy (overemphasize mistrust): Withdrawal, neurotic, depressive, afraid

Applicable to the first year or two of life, infants in this stage develop a healthy balance of trust or mistrust based on their experiences with early caregivers. A healthy balance of trust translates to a general sense of hope and safety in the world while simultaneously knowing when caution is warranted. Persons who have had traumatic childhoods or whose parents overly protected them often have confusion over when, where, and whom to trust, resulting in a sense of being either unrealistically entitled or needlessly afraid.

Autonomy versus Shame and Doubt: Toddler Stage

Maladaption (overemphasis of autonomy): Impulsivity, recklessness, inconsiderate, thoughtless
Malignancy (overemphasis of shame/doubt): Compulsion, constrained, self-limiting

During toddlerhood, children develop a sense of autonomy and having an impact in their lives while also learning the limits of their abilities. If caretakers are either neglectful or overly protective, children become overburdened with a sense of shame and may grow up to have lingering issues that manifest as extreme self-doubt or debilitating shame and/or shyness. Alternatively, if parents do not allow their children to experience shame and self-doubt, these children tend to become impulsive and inconsiderate of others.

Initiative versus Guilt: Preschool and Kindergarten Age

Maladaptation (overemphasis of initiative): Ruthless, exploitative, uncaring, dispassionate
Malignancy (overemphasis of guilt): Inhibition, risk-aversive, unadventurous

During preschool and kindergarten, children transition through a developmental stage in which they develop a sense of initiative and purpose tempered by guilt when their actions hurt others. Children who have either overly protective or neglectful parents may develop a strong sense of guilt and insecurity about making their own choices, leading to risk avoidance and inhibition. Alternatively, children who have an underdeveloped awareness of guilt and how their actions affect others become overly aggressive and even ruthless.

Industry versus Inferiority: School Age

Maladaptation (overemphasis of industry): Narrowly virtuous, workaholic, obsessive specialist
Malignancy (overemphasis of inferiority): Inertia, lazy, apathetic, purposeless

In the early years in school, children learn new skills, developing a sense of competence from which they build their sense of self-worth; thus, the task at this stage is to engage in industrious activities to build confidence in their abilities. Children who are frequently criticized or compared to others and found to be lacking develop a pervasive sense of inferiority. Recent research also shows that overly praised children who are protected from experiencing failure and obstacles also develop a sense of inferiority because they are thwarted from developing a genuine sense of mastery (Seligman, 2002). Thus, contrary to their parents' intentions, children who are constantly sheltered from the feelings of losing a game, getting bad grades, being left out, and similar feelings of inferiority, are actually likely to develop a lingering sense of inadequacy as they get older that can manifest as "underachieving" down the road. Alternatively, overly identifying with one's industriousness can result in obsessiveness in their activities.

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Identity versus Identity Confusion: Adolescence

Maladaptation (overemphasis of identity): Fanaticism, self-important, extremist
Malignancy (overemphasis of identity confusion): Repudiation, socially disconnected, cut-off

Few developmental stages are more fabled—or as well researched—as adolescence. Erickson saw this as a time of identity development when a person first begins to answer questions, such as who am I, and how do I fit in? Developmentally, this is a time of exploring possible identities and social roles, which often takes the form of wild outfits, colorful hair, rebellious music, rotating social groups, and other ways to magnificently annoy one's parents. Teens who are not allowed to explore their identity or are made to feel guilty for not pursuing certain life paths may experience role confusion, failing to identify a clear or viable sense of identity. Alternatively, role confusion can also take the form of failing to adopt viable social roles and instead developing a reactive identity that is based on a rebellious need to "not be" what someone wants, often taking the form of drug use, a radical social group, gang membership, or dropping out of high school. In such cases, teens are not able to conceive of themselves as productive members of one's family or society.

Intimacy versus Isolation: Young Adulthood

Maladaptation (overemphasis of intimacy): Promiscuous, needy, vulnerable
Malignancy (overemphasis of isolation): Exclusivity, loner, cold, self-contained

In recent generations, young adulthood has become much longer than in years prior, as more people seek higher education, and views of marriage and "settling down" change. During this time, people establish intimate relationships in their personal, social, and work lives, developing their own families and social networks. People who struggle with this stage can become either overly focused on their relationships, possibly becoming sexually promiscuous or overly identified with being in a relationship, or increasingly socially isolated.

Generativity versus Stagnation: Adulthood

Maladaptation (overemphasis of generativity): Overextension, do-gooder, busy-body, meddling
Malignancy (overemphasis of stagnation): Rejecting, disinterested, cynical

The developmental tasks of adulthood focus on feeling as though one meaningfully contributes to society and the succeeding generations, and this stage is often measured by whether one is satisfied with life accomplishments. A midlife crisis refers to feeling that one's life is stagnant, off course, and/or in need of fixing, which some people pursue by trying to make radical life changes—sometimes these help, and at other times these get a person even more off course. Often, the consequences of developmental deficiencies from prior stages come to a head during this time and can now be worked through and more readily addressed. Additionally, developmental issues at this stage can take the form of being overly involved and extended in one's social or work world or, alternatively, becoming cynical and disconnected.

Integrity versus Despair: Late Adulthood

Maladaptation (overemphasis of integrity): Presumption, conceited, pompous, arrogant
Malignancy (overemphasis of despair): Disdain, miserable, unfulfilled, blaming

The final developmental stage is an increasingly important one for counselors to understand, because a great number of elderly people are receiving professional services. During this stage, people balance a sense of integrity with a sense of despair as they look back over their lives and face the inevitability of death. Those who are able to face the end of life with a greater sense of integrity and wisdom are able to integrate the experiences of their life, to make meaning and accept what and who they have been. In contrast, others struggle to make peace with their lives and with life more generally and experience inconsolable sadness and loss or, alternatively, develop a false sense of self-importance that is conveyed as arrogance and self-righteousness.

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Adlerian Style of Life Theme

❑ Control: _____

❑ Superiority: _____

❑ Pleasing: _____

❑ Comfort: _____

Basic Mistake Misperceptions: _____

_____

_____

When working with clients, one of the most important areas that Adlerian counselors assess is a person's *style of life*, which can be described a person's characteristic way of thinking, doing, feeling, living, and striving: one's road map for life. This "style" or map of life both shapes and is shaped by the goals we choose for our lives, and it becomes the thread that runs through all aspects of our lives. Eckstein (2009) identifies four general patterns that are commonly adopted as a style of life: control, superiority, pleasing, and comfort. Although these are not the only way to assess a client's style of life, they are an easy way to begin. A person may have more than one of these themes in their style of life.

Control

People whose lifestyle is characterized by control frequently seek to control others, themselves, and/or the situation in order to create a sense of safety and security. However, you have no doubt lived long enough to realize that total control over anyone, including oneself, is not humanly possible. Thus, those whose life theme includes elements of control are frequently frustrated, often perceiving others as being resistant or difficult. These people tend to often be drawn into power struggles and into distancing themselves from people and situations over which they have no control. Counseling can help people with a controlling lifestyle accept what they cannot change and develop greater tolerance for others.

Superiority

Those whose life theme is characterized by superiority, not to be confused with control, are commonly referred to as "perfectionists." They need to be better than others as well as "right," useful, and competent. However, underneath an outer layer of what appears to be superiority, they tend to have an ongoing inner doubt about whether they are "good enough." Inside they tend to be hard on themselves, often taking on more than they can reasonably handle. Sometimes this standard of superiority gets projected onto others, especially children, and the person becomes impossible to please. Counselors can help those with superiority life themes develop more realistic expectations for themselves and others.

Pleasing

Those whose life theme involves pleasing, one of the easiest to work with and most commonly seen in counseling settings, focus their energies on understanding the needs of others and finding ways to meet them. They often need everyone else to be happy before they can be happy, thus making their happiness dependent on how they are treated by others. Typically, a person with a pleasing lifestyle gives and gives and gives, and then at a certain point becomes resentful. In some cases, others take advantage of them or abuse them; in other cases, those around them are unaware of the sacrifices they are making. Their fear of rejection and habit of pleasing others at the expense of their own integrity

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can cause significant hardship in their lives. In counseling, they can learn to set healthy boundaries and find ways to assert their needs in relationships while still respecting those of others.

Comfort

Those whose life theme involves comfort seek comfort at the expense of taking the risks involved with pursuing life goals and achievement. They tend to avoid the stress of responsibility and delayed reward, often due to a sense of inadequacy or fear of failure. In moderation, seeking comfort leads to underachieving, while in its extreme, it may take the form of addiction. Counselors can help those with this theme to take small steps toward their goals, emphasizing small successes along the way.

Basic Mistake Perceptions

Each person's style of life reveals his or her *private logic* about how life and the world work. Children begin developing their personal maps of the universe—their private logic—from their earliest experiences. Thus, virtually everyone ends up with a system of private logic that has some *basic mistakes*, perceptions about the world that are inaccurate. Basic mistakes are similar to what cognitive counselors call *irrational beliefs* but refer to the core and most general irrational beliefs that inform one's view of life, self, and others. Adlerian counseling involves helping people identify these often unconscious or semiconscious erroneous assumptions about life, in order to enable a person to develop a system of private logic that supports him or her in pursuing life goals.

Basic mistakes are individual and unique. Thus, assessing them requires listening carefully to what clients say and asking about their thinking process in situations related to the presenting problem: "What did you find so offensive in what your husband said?" or "What motivated you to take such a desperate action?" With careful listening, astute observations, and probing questions, counselors can help clients identify basic mistake misperceptions that contribute to their current concerns. Examples include the following:

- *Overgeneralizations:* "People cannot be trusted"; "No one cares about me."
- *Unrealistic expectations:* "I should always be happy"; "Life should be easy."
- *Unsustainable goals:* "Everyone must be happy for me to be happy"; "I must always be the best at what I do."
- *Misperceptions about life/God:* "Life should be fair"; "God will give me what I want."
- *Denying one's worth:* "I will never be good enough"; "I am not worth loving."
- *Problematic values:* "I must get to the top at any cost"; "I do not apologize for my actions."

Humanistic-Existential Conceptualization

Expression of Authentic Self

VI. Humanistic-Existential Conceptualization

Expression of Authentic Self

Problems: Are problems perceived as internal or external (caused by others, circumstance, etc.)? ❑ Predominantly internal ❑ Mixed ❑ Predominantly external

Agency and Responsibility: Is self or other discussed as agent of story? Does client take clear responsibility for situation? ❑ Strong sense of agency and responsibility ❑ Agency in some areas ❑ Little agency; frequently blames others/situation ❑ Often feels victimized

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Recognition and Expression of Feelings: Are feelings readily recognized, owned, and experienced? ❑ Easily expresses feelings ❑ Identifies feelings with prompting ❑ Difficulty recognizing feelings

Here-and-Now Experiencing: Is the client able to experience full range of feelings as they are happening in the present moment? ❑ Easily experiences emotions in present moment ❑ Experiences some present emotions with assistance ❑ Difficulty with present moment experiencing

Personal Constructs and Facades: Is the client able to recognize and go beyond roles? Is identity rigid or tentatively held? ❑ Tentatively held; able to critique and question ❑ Some awareness of facades and construction of identity ❑ Identity rigidly defined; seems like "fact"

Complexity and Contradictions: Are internal contradictions owned and explored? Is client able to fully engage the complexity of identity and life? ❑ Aware of and resolves contradictions ❑ Some recognition of contradictions ❑ Unaware of internal contradictions

Shoulds: Is client able to question socially imposed shoulds and oughts? Can client balance desire to please others and desire to be authentic? ❑ Able to balance authenticity with social obligation ❑ Identifies tension between social expectations and personal desires ❑ Primarily focuses on external shoulds

List shoulds: _____

Acceptance of Others: Is client able to accept others and modify expectations of others to be more realistic? ❑ Readily accepts others as they are ❑ Recognizes expectations of others are unrealistic but still strong emotional reaction to expectations not being met ❑ Difficulty accepting others as is; always wanting others to change to meet expectations

Trust of Self: Is client able to trust self as process (rather than a stabile object)? ❑ Able to trust and express authentic self ❑ Trust of self in certain contexts ❑ Difficulty trusting self in most contexts

In humanistic approaches to counseling, such as person-centered and Gestalt, assessment focuses on the person's ability to experience and express one's authentic self. As you can imagine, this is a subtle process that is difficult to assess. Carl Rogers (1961) identifies several telltale signs of authenticity. These are discussed in the following sections.

Problems

Rogers noticed that as people move toward greater authenticity, they begin to see problems and solutions to problems primarily as an internal rather than an external matter. People early in the growth process tend to see problems as caused by others or attributable to external circumstances, such as someone not doing what he or she wants or an unfortunate event. In contrast, as people move toward greater authenticity, they begin to describe problems as their needing to take some action or respond differently to a situation; they no longer see others or situations as the problem; rather, the problem is that they need to change their role in the situation.

Agency and Responsibility

When listening with an attuned ear to clients, it is often easy to discern whether they see themselves as the agent of their lives and therefore take responsibility for their actions as well as the situations. Early in the growth process, clients tend to blame others or their circumstances or report feeling like a victim. They describe events happening *to them*, with others serving as the agents in the story. In contrast, as they begin to become more self-actualized, the same circumstances are described with the client as the agent or protagonist of the story, and they take responsibility for the situation and their response.

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Recognition and Expression of Feelings

Humanistic counselors carefully observe a person's ability to recognize, own, express, and experience their emotions. As people become more self-actualized, they more readily access and manage emotions. When some clients begin counseling, they have extreme difficulty identifying their emotions: when asked what they are feeling, they can only describe what they are thinking. Through the counseling process, they learn to identify and experience their emotions more fully. Finally, the counselor helps them to "own" them (take responsibility) and respectfully express them in appropriate contexts with appropriate people.

Here-and-Now Experiencing

Once a counselor has helped a client to more readily identify emotions, the next step is to be able to experience and express emotions as they arise in the present moment. Typically, clients are first able to do this in a safe environment in session with their counselor and then in less controlled, real-life situations. Clients who learn how to experience emotions in the here and now can feel emotions as they arise, are consciously aware of feeling these emotions, and can do so without overreacting to them. For example, if a client gets disappointing news about not getting a job or promotion, he can feel the disappointment and is aware that he is feeling the disappointment yet does not overreact by getting angry, depressed, or self-harming (drinking, etc.).

Personal Constructs and Facades

Carl Rogers paid careful attention to the social roles and facades his clients played. His counseling approach aimed to get people to move beyond these limiting personal constructs—rigid definitions of self—to move toward a more fluid form of identity that was constantly evolving and expanding. The more rigidly one holds to a personal construct—"I am a hard worker" or "I am beautiful"—the more limited one's life becomes, because so much energy must go toward maintaining this identity. Thus, humanistic counselors look for more tentatively held ideas of self and personhood as a sign of living more authentically.

Complexity and Contradictions

News flash: You are a hypocrite. I am a hypocrite. We are all riddled with contradictions, complexities, and confusions. As a person becomes more self-aware, the better able one is to see these contradictions and accept them as part of what it means to be human.

"Shoulds"

Also targeted by Gestalt and cognitive counselors, "shoulds" and "oughts" are socially imposed rules about how one should think, feel, and behave. Every culture has these "shoulds"; in fact, in essence, each culture is a list of "shoulds." Thus, it is impossible to live with other humans and not have a list of socially defined "shoulds." The key is how one relates to these. If a person swallows them whole and contorts themselves to fit into these "shoulds," the authentic self has little room for expression. Instead, the ideal is to thoughtfully balance one's need for authentic self-expression with the socially imposed "shoulds," sometimes having to forgo social acceptance in order to maintain one's integrity. That said, someone who flaunts going against cultural norms is not expressing the authentic self but rather finding identity by being a reactive rebel who is still defined by socially imposed "shoulds"—just in negative relief.

Acceptance of Others

Relating to other humans is challenging. Even in the best of relationships, at a certain point a fundamental difference or failure occurs that leaves one or both feeling betrayed, hurt, or angry. Accepting imperfection in others tends to occur when one begins to accept it in oneself. Thus, humanistic counselors carefully assess clients' abilities to accept others and to modify their expectations of others to be more realistic. In theory,

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it would be great if everyone spoke with kind words in a kind tone to everyone. In theory, it would be great if everyone could follow through on their promises and act with integrity in difficult situations. The more you are in relationship with others, the more you realize that such perfection is not possible. That said, it is important to keep striving for these ideals and to balance this realism with realistic expectations for thoughtful and kind behavior.

Trust of Self

Finally, humanistic counselors assess the extent to which clients are able to experience their identity as *process* rather than as a stabile object. People who experience their identity as a stabile "thing" are attached to labels, routines, status, objects, and anything else that symbolizes their identities. As a person becomes more self-actualized, these things matter less and less, and a person becomes more comfortable with the idea that identity is fluid and evolving. Important identity factors today—grades, degree, job, relationship, and children—will likely be less important at some point in the future. Self-actualization involves trusting the ongoing unfolding of the self with less and less need to label it, pin it down, or claim it.

Existential Analysis

Existential Analysis

Sources of Life Meaning (as described or demonstrated by client): _____

_____

_____

General Themes of Life Meaning: ❑ Personal achievement/work ❑ Significant other ❑ Children ❑ Family of origin ❑ Social cause/contributing to others ❑ Religion/spirituality
❑ Other: _____

Based on existential logotherapy (Frankl, 1963), existential analysis of a client's life situation involves looking at his or her life from the highest possible vantage point. It's such a "big-picture" view that it is easy to forget when one is focused on so many other details, such as frequency of symptoms, childhood history, and current relationships. However, this wide-angle view often provides invaluable information about how to expedite the counseling process. Two initial areas for assessment are the following:

- Sources of life meaning: What inspires the client and makes him or her feel whole and fulfilled?
- Satisfaction with and clarity of life direction: Does the client have a clear sense of purpose and direction for his or her life? Is life on or off track?

The importance of these perennial existential questions has had a boost from science in recent years. In studying happiness and life satisfaction, positive psychologists report a strong correlation between having a sense of meaning and purpose and being happy (Seligman, 2002). Thus, counselors need to understand, at the outset of counseling, where clients find meaning and purpose, in order to effectively guide treatment and help the client achieve greater levels of happiness.

An existential analysis of meaning and purpose is particularly useful when working with certain types of clients. For example, when working with clients who have suicidal feelings, counselors can assess for sources of life meaning and life satisfaction in order to determine how serious the threat is and how best to motivate clients to value life again. Similarly, clients who struggle with depression have often lost their sense of direction in life and need to have their life dreams reinvigorated. As is developmentally expected, most

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teens I work with struggle with issues of life meaning and direction and appreciate being able to discuss these personal issues with an open-minded and patient adult. In all cases, knowing where clients draw their inspiration reveals what will ultimately motivate them toward change, no matter what the initial presenting concern.

Gestalt Contact Boundary Disturbances

Gestalt Contact Boundary Disturbances

- ❑ *Desensitization:* Failing to notice problems
- ❑ *Introjection*: Take in others' views whole and unedited
- ❑ *Projection*: Assign undesired parts of self to others
- ❑ *Retroflection*: Direct action to self rather than other
- ❑ *Deflection*: Avoid direct contact with another or self
- ❑ *Egotism:* Not allowing outside to influence self
- ❑ *Confluence*: Agree with another to extent that boundary blurred

Describe: _____

_____

As described in Chapter 8, Gestalt counselors view each moment of lived experience primarily in terms of a form of *contact* between the self (organism) and the outside world (others and environment; Perls, Hefferline, & Goodman, 1951; Yontef, 1993). If a person is able to make direct contact and authentically *encounter* the outside world, the person is living a full and authentic life. However, for a variety of reasons—early life lessons, fears, or social dictates—people avoid genuine contact to protect themselves. These *contact boundary disturbances* refer to distortions in perceptions of self or others.

An encounter involves a continuum of seven phases, beginning with initial perception, moving toward direct encounter, and ending in withdrawal. The human experience involves an endless ebb and flow of making contact with one person/object/idea and then withdrawing, then making contact and withdrawing from another, in an endless series of connections and disconnections. A person can avoid contact at any of the seven phases using specific resistance processes at each stage (Woldt & Toman, 2005):

Continuum Phase	Resistance Process	Example of Resistance
1. *Sensation/perception:* Organism perceives input from environment.	*Desensitization:* Failing to notice problems	Ignoring increasing violence by partner in fights
2. *Awareness:* One's lived experience becomes focused on the environmental sensation.	*Introjection:* Take in others' views whole and unedited	Becoming what your parents wanted you to be
3. *Excitement/mobilization:* The organism mobilizes to prepare for contact.	*Projection:* Assign undesired parts of self to others	Rejecting sexual aspects of self and then perceiving others as "oversexed"
4. *Encounter/action:* The organism takes action to engage the other.	*Retroflection:* Direct action to self rather than other	Rather than creating conflict with others, focusing criticism on self
5. *Interaction/full contact:* A back-and-forth exchange happens; the self becomes part of "we."	*Deflection:* Avoid direct contact with another or self	Working long hours to avoid spouse or avoiding own emotions

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Continuum Phase	Resistance Process	Example of Resistance
6. *Assimilation/integration:* The organism takes in and integrates new information, behavior, and so on.	*Egotism:* Not allowing outside to influence self	Claiming to be "in love" but not being open to changing self to meet needs of relationship
7. *Differentiation/withdrawal:* The organism withdraws from contact and returns to its individual state.	*Confluence:* Agree with another to extent that boundary blurred	Agreeing with spouse to extent that one no longer allows self to have a divergent opinion

When assessing clients, Gestalt counselors look for where their clients are "stuck" in the cycle of making contact and direct their interventions to encourage clients to make contact and complete the encounter cycle.

Cognitive-Behavioral Conceptualization

VII. Cognitive-Behavioral Conceptualization

Baseline of Symptomatic Behavior

Symptom #1 (behavioral description): _____

Frequency: _____

Duration: _____

Context(s): _____

Events Before: _____

Events After: _____

Symptom #2 (behavioral description): _____

Frequency: _____

Duration: _____

Context(s): _____

Events Before: _____

Events After: _____

Baseline Assessment

The *Baseline Assessment of Symptomatic Behavior* originated in behavioral counseling (Spiegler & Guevremont, 2003) but is commonly required by insurance companies and other third-party payers whose preferred model is the *medical model*, which focuses on observable symptoms. Therefore, if you like to get paid, it's a good idea to become competent in the art of baseline assessment. Thankfully, compared to everything else in this assessment, it's a snap.

Steps to Baseline Assessment

Step 1. Define the problem behavior in specific, observable behaviors that are easily counted.

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Examples: To measure depression, you could measure any of the following: (a) hours per day with depressed mood; (b) days per week with mild, moderate, or severe depressed mood; or (c) days per week avoiding social contact and/or normal activities. Step 2: Get a baseline: Create a chart for the client that collects the following data:

- *Frequency of problem behavior:* Measured in minutes, hours, days, or weeks.
- *Duration and/or severity of each episode:* Duration can be in minutes or hours; severity is typically measured as mild, moderate, or severe.
- *Context in which the behavior happened:* Could be place, relationship, timing, or some other potentially contextual trigger for the behavior.
- *Events before each episode:* Used to identify potential triggers (e.g., rain, an argument).
- *Events after each episode:* Used to identify potential reinforcement and/or clarify trigger of the behavior (e.g., when her husband comes home the wife's anxiety diminishes).

Sample of Baseline Assessment Chart

	Frequency	Duration/ Severity	Context	Events Before	Events After
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					

The client then completes the chart for a period of one to four weeks to get a baseline assessment of the problem behavior. This becomes the measuring point for progress once treatment commences, so that progress can be closely measured. Relying on the most objective data available in mental health, baseline assessment is considered one of the best measures of progress. However, for those who have spent some time collecting such data, it becomes quickly apparent that because these data rely heavily on client recall and description, they are less consistent and reliable as one might hope. In fact, often a spouse or parent may be a more reliable source of behavioral information than the client trying to remember their internal states.

A-B-C Analysis of Irrational Beliefs

A-B-C Analysis of Irrational Beliefs

Activating Event ("Problem"): _____

Consequence (Mood, behavior, etc.): _____

Mediating Beliefs (Unhelpful beliefs about event that result in C):

1. _____
2. _____
3. _____

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One of the more common assessment techniques in cognitive-behavior approaches, Albert Ellis's (1999) A-B-C framework is used to identify problematic beliefs that result in undesirable emotions and behaviors. The A-B-C framework works as follows:

A = Activating event → **B** = Belief → **C** = Consequence

In this case, A, the activating event, triggers B, a belief, that results in C, a consequence. In theory, this happens with all events all the time. However, when a person has what Ellis terms an irrational belief, or what I prefer to call a problematic belief, the consequences are essentially the presenting problem for which the client is seeking help. Here are some examples:

Here are some examples:

- **A** = Fight with boyfriend → **B** = Our relationship is in trouble; no one will ever love me → **C** = Feeling depressed; acting desperate; text messaging every two minutes; eating a pint of ice cream.
- **A** = Trip to shopping mall → **B** = People judge me by the way I look; I am not as good as everyone else; something is wrong with me → **C** = Feelings of inadequacy; feeling anxious and panicked; afraid to make eye contact; avoiding people; leaving the mall early; overspending online at home.

The role of the counselor is to help identify B, the unhelpful belief, because most clients *experience* the chain of events as A → C and describe it as "I am depressed *because* my boyfriend and I had a fight," not "I am depressed because I believe no one will ever love me." To identify these underlying beliefs, counselors can ask questions such as the following:

Questions for Identifying Unhelpful Beliefs

- When you think about the activating event (it helps to name it), why does it make sense to then feel _____ (C) or do _____ (C)?

  Example: When you think about going to the mall (A), why does it make sense to feel anxious (C) and leave as soon as possible (C)?
- What beliefs do you have about yourself and/or ___ (A) that may lead you to feel _____ (C) or do _____ (C)?

  Example: What beliefs do you have about you or your relationship that may lead you to feel depressed or act impulsively after a fight?

Beck's Schema Analysis

Beck's Schema Analysis

Identify frequently used cognitive schemas:

❑ *Arbitrary inference:* _____

❑ *Selective abstraction:* _____

❑ *Overgeneralization:* _____

❑ *Magnification/Minimization:* _____

❑ *Personalization:* _____

❑ *Absolutist/dichotomous thinking:* _____

❑ *Mislabeling:* _____

❑ *Mindreading:* _____

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Another common cognitive assessment technique is *schema analysis*, pioneered by Aaron Beck (1976). Schema is a technical psychological term that refers to a structured set of beliefs about some aspect of the world, such as one's worth, others' motives, or luck. To connect back up with Ellis's A-B-C framework, Beck's schema analysis can be viewed as a categorization of specific unhelpful beliefs. Assessing unhelpful beliefs using Beck's categorization of schemas can be very helpful in the counseling process by naming the beliefs more concretely and by identifying habitual patterns of thought. Categories of schema include, but are not limited to, the following:

- *Arbitrary inference:* Drawing conclusions without sufficient or relevant evidence, including pessimism and catastrophizing (e.g., assuming that someone is angry with you just because they do not return a phone call when expected).
- *Selective abstraction:* Making assumptions based on certain facts while ignoring other—usually more positive—facts (e.g., assuming that you will lose a long-term friend because of a minor miscommunication).
- *Overgeneralization:* Holding extreme beliefs based on relatively little data (e.g., because I was not a good soccer player in elementary school, I am terrible at all sports).
- *Magnification and minimization:* Overemphasizing or underemphasizing a particular fact and drawing inaccurate conclusions; in statistical terms, making assumptions that are based on an unrepresentative data set (e.g., believing that no one thinks you are beautiful because of a comment that one person made).
- *Personalization:* Assuming that an external event or someone else's action somehow says something about you (e.g., believing something is wrong with you because a partner cheats on you—hint, hint, *you* didn't make the choice to be unfaithful).
- *Absolutist or dichotomous thinking:* Categorizing things as all-good or all-bad or as either-or extremes (e.g., either she loves me or she doesn't).
- *Mislabeling:* Unfairly characterizing one's entire identity on the basis of limited events (e.g., I am a terrible counselor because one client did not return for a second session).
- *Mindreading:* Believing that you know what another person is thinking without sufficient supporting evidence (e.g., I know he does not like me because of the look on his face when I am at the meetings).

Family Systemic Conceptualization

VIII. Family Systems Conceptualization

Family Life Cycle Stage

❑ Single adult ❑ Marriage ❑ Family with Young Children ❑ Family with Adolescent Children ❑ Launching Children ❑ Later Life

Describe struggles with mastering developmental tasks in one of these stages: _____

_____

Boundaries with

Parents ❑ Enmeshed ❑ Clear ❑ Disengaged ❑ NA: *Describe:* _____

Significant Other ❑ Enmeshed ❑ Clear ❑ Disengaged ❑ NA: *Describe:* _____

Children ❑ Enmeshed ❑ Clear ❑ Disengaged ❑ NA: *Describe:* _____

Extended Family ❑ Enmeshed ❑ Clear ❑ Disengaged ❑ NA: *Describe:* _____

Other: Name ❑ Enmeshed ❑ Clear ❑ Disengaged ❑ NA: *Describe:* _____

Typical style for regulating closeness and distance with others: _____

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Triangles/Coalitions

❑ Coalition in family of origin: *Describe:* _____

❑ Coalitions related to significant other: *Describe:* _____

❑ Other coalitions: _____

Hierarchy between Self and Parent/Child ❑ NA

With own children ❑ Effective ❑ Rigid ❑ Permissive

With parents (for child/young adult) ❑ Effective ❑ Rigid ❑ Permissive

Complementary Patterns with Name: ❑ Pursuer/distancer ❑ Over-/underfunctioner

❑ Emotional/logical ❑ Good/bad parent ❑ Other: *Describe*

Example of complementary pattern: _____

Intergenerational Patterns

Substance/Alcohol Abuse: ❑ NA ❑ History: _____

Sexual/Physical/Emotional Abuse: ❑ NA ❑ History: _____

Parent/Child Relations: ❑ NA ❑ History: _____

Physical/Mental Disorders: ❑ NA ❑ History: _____

Family strengths: Describe: _____

Stage of Family Life Cycle Development

When assessing families, it is helpful to identify their stage in the life cycle (Carter & McGoldrick, 1999). Each stage is associated with specific developmental tasks; symptoms arise when families are having difficulty mastering these tasks:

- *Leaving home: single adult:* Accepting emotional and financial responsibility for self.
- *Marriage:* Commit to new system; realigning boundaries with family and friends.
- *Families with young children:* Adjust marriage to make space for children; join in child-rearing tasks; realign boundaries with parents/grandparents.
- *Families with adolescent children:* Adjusting parental boundaries to increase freedom and responsibility for adolescents; refocus on marriage and career life.
- *Launching children:* Renegotiating marital subsystem; developing adult-to-adult relationships with children; coping with aging parents.
- *Family in later life:* Accepting the shift of generational roles; coping with loss of abilities; middle generation takes more central role; creating space for wisdom of the elderly.

Interpersonal Boundaries

A family counseling term that has found its way into many self-help books, *boundaries* are the rules for negotiating interpersonal closeness and distance (Minuchin, 1974). These rules are generally unspoken and unfold as two people interact over time, each defining when, where, and how he or she prefers to relate to the other. Structural counselors characterize boundaries in one of three ways—clear, diffuse, or rigid—all of which are strongly influenced by culture.

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Clear Boundaries and Cultural Variance

Clear boundaries refer to a range of possible ways couples can negotiate a healthy balance between closeness (we-ness) and separation (individuality). Cultural factors shape how much closeness versus separation is preferred. Collectivist cultures tend toward greater degrees of closeness, whereas individualistic cultures tend to value greater independence. The best way to determine if a couple's boundaries are clear is to determine whether symptoms have developed in the individual, couple, or family. If they have, it is likely that there are problems with the boundaries being too *diffuse* or too *rigid*. Most people who come in for counseling have reached a point where previous boundaries and rules for relating that may have worked in one context are no longer working. For relationships to weather the test of time, couples, families, and even friends must constantly renegotiate their boundaries (rules for relating) to adjust to each person's evolving needs. The more flexible people are in negotiating these rules, the more successful they will be in adjusting to life transitions and setbacks.

Enmeshed/Diffuse Boundaries

When a couple or family begins to overvalue togetherness at the expense of respecting the individuality of each, their boundaries become *diffuse*, and relationship becomes *enmeshed* (note: technically, boundaries are not enmeshed; they are diffuse). In these relationships, individuals may feel that they are being suffocated, that they lack freedom, or that they are not cared for enough. Often, in these relationships, people feel threatened whenever the other disagrees or does not affirm them, resulting in an intense tug-of-war to convince the other to agree with them. Couples with diffuse boundaries may also have diffuse boundaries with their children, families of origin, and/or friends, resulting in these outside others becoming overly involved in one or both of the partners' lives (e.g., involving parents, friends, or children in a couple's arguments).

Disengaged/Rigid Boundaries

When relationships emphasize independence over togetherness, boundaries can become *rigid* and the relationship *disengaged*. In these relationships, people may not allow others to influence them, often choosing careers over relationship priorities, and may frequently have minimal emotional connection. In couple partnerships that are disengaged, one or the other may compensate for distance in the couple relationship by having diffuse boundaries with children, friends, family, or an outside love interest (e.g., an emotional or physical affair). Often difficult to accurately assess, the key indicator of rigid boundaries is whether they are creating problems individually or for the partnership.

Questions for Assessing Boundaries

Here are some sample questions to think about while working with an individual, couple, or family to assess boundaries:

- Does the couple have clear couple boundaries that are distinct from their parenting and family-of-origin relationships?
- Does the couple spend time alone not talking about the children?
- Do family members experience anxiety or frustration when there is a difference of opinion?
- Is one hurt or angry if another has a different opinion or perspective on a problem?
- Do they use "we" or "I" more often when speaking? Is there a balance?
- Does each have a set of personal friends and activities separate from the family and partnership?
- How much energy goes into the family versus career and outside interests?
- What gets priority in their schedules? Children? Work? Personal activities? Couple time?

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Triangles/Coalitions: Problem Subsystems and Triangles

Problem systems are identified in most systemic family counseling approaches. Triangles (Kerr & Bowen, 1988), covert coalitions (Minuchin & Fishman, 1981), and cross-generational coalitions (Minuchin & Fishman, 1981) all refer to a similar systemic process: tension between two people is resolved by drawing in a third (or fourth, "*tetrad*"; Whitaker & Keith, 1981) person to stabilize the original dyad. Many counselors include inanimate objects or other processes as potential "thirds" in the triangulation process, such as drinking, drug use, work, hobbies, and so on, that are used to help one or both partners soothe their internal stress at the expense of the relationship.

Counselors assess for triangles and problematic subsystems in several ways:

- Clients overtly describe another party as playing a role in their tension; in these cases, the clients are aware at some level of the process going on.
- When clients describe the problem or conflict situation, another person plays the role of confidante or takes the side of one of the partners (e.g., one person has a friend or another family member who takes his or her side against the other).
- After being unable to get a need met in the primary dyad, a person finds what he or she is not getting in another person (e.g., a mother seeks emotional closeness from a child rather than from her husband).
- When counseling is inexplicably "stuck," there is often a triangle at work that distracts one or both parties from resolving critical issues (e.g., an affair, substance abuse, a friend who undermines agreements made in counseling).

Identifying triangles early in the assessment process enables counselors to intervene more successfully and quickly in a complex set of family dynamics.

Hierarchy Between Child and Parents

A key area in assessing parent and child relationships is the parent-child hierarchy. When assessing parental hierarchy, counselors must ask themselves, Is the parent-child hierarchy developmentally and culturally appropriate? If the hierarchy is appropriate, there are generally minimal problems with the child's behavior. Generally, if the child is exhibiting symptoms or there are problems in the parent–child relationship, there is some problem in the hierarchical structure: either an excessive (authoritarian) or an insufficient (permissive) parental hierarchy, given the family's current sociocultural context(s). Immigrant families most always have two different sets of cultural norms for parental hierarchy (the traditional and the current cultural context), resulting in a difficult task of finding a balance between the two.

Assessing hierarchy is critical because it tells the counselor where and how to intervene. Often, inappropriate interventions are used if the counselor assesses only the symptoms. For example, although children with ADHD have similar symptoms—hyperactivity, defiance, failing to follow through on parents' requests, and so on—these same symptoms can occur in two dramatically different family structures: either too much or too little parental hierarchy. In the cases where the parental hierarchy is too rigid, the counselor works with the parents to soften this, develop a stronger personal relationship with the child, and set developmentally and culturally appropriate expectations. On the other hand, if there is not enough parental hierarchy, the counselor works with the parents to increase their consistency with consequences and to increase their attention to setting limits and rules. Thus, the same set of symptoms can require very different interventions.

Complementary Patterns

Complementary patterns characterize most couple relationships to a certain degree and can also characterize sibling relationships, friendships, and other relationships. *Complementary* in this case refers to each person taking on opposite or complementary roles that exist in a range from functional to problematic. For example, a complementary relationship of introvert/extrovert can exist in a balanced and well-functioning relationship as well as an out-of-balance, problematic relationship; the difference is in the rigidity of the pattern.

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Classic examples of complementary roles that often become problematic include pursuer/distancer, emotional/logical, overfunctioner/underfunctioner, friendly parent/strict parent, and so on. In fact, Gottman (1999) indicates that the female-pursue (demand) and male-withdraw pattern exists to some extent in the majority of marriages he studied. However, in distressed marriages, this becomes exaggerated and begins to be viewed as innate personality traits. Assessing for these patterns can help counselors intervene around these interactional dynamics. In most cases, people readily identify their complementary roles in their complaints about a relationship: "he's too strict with the kids," "she always emotionally overreacts," "I have to do it all the time," "she never wants sex," and so on. These broad, sweeping descriptions of the other denote a likely problematic complementary pattern.

Intergenerational Patterns

Assessing for intergenerational patterns is easiest when using a genogram (McGoldrick, Gerson, & Petry, 2008), which provides a visual map of intergenerational patterns. Counselors can create comprehensive genograms that map numerous intergenerational patterns, or problem-specific genograms that focus on patterns related to the presenting problem—to learn how family members have dealt with similar problems across generations (e.g., how other couples have dealt with marital tension). Patterns that frequently included in genograms are the following:

- Substance and alcohol abuse and dependence
- Sexual, physical, and emotional abuse
- Personal qualities and/or family roles; complementary roles (e.g., black sheep, rebellious one, overachiever/underachiever)
- Physical and mental health issues (e.g., diabetes, cancer, depression, psychosis)
- Historical incidents of the presenting problem, either with the same people or how other generations and family members have managed this problem.

Try It Yourself

Find a partner or put your own family on paper, and create a genogram that includes the above information. Does putting it on paper help you see patterns more clearly?

Postmodern-Feminist Conceptualization

Solutions and Unique Outcomes

IX. Solution-Based and Cultural Discourse Conceptualization (Postmodern)

Solutions and Unique Outcomes

Attempted Solutions that DIDN'T or DON'T work:

1. _____

2. _____

3. _____

Exceptions and Unique Outcomes: Times, places, relationships, contexts, and so on, when problem is less of a problem; behaviors that seem to make things even slightly better:

1. _____

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2. _____

3. _____

Miracle Question Answer: If the problem were to be resolved overnight, what would client be doing differently the next day? (Describe in terms of doing X rather than not doing Y).

1. _____

2. _____

3. _____

Attempted Solutions That Did *Not Work*

When assessing solutions, counselors need to assess two kinds: those that have worked and those that have not. The Mental Research Institute group (Watzlawick et al., 1974) and cognitive-behavioral therapy counselors (Baucom & Epstein, 1990) are best known for assessing what has not worked, although they use these in different ways when they intervene. With most clients, it is generally easy to assess failed previous solutions.

Questions for Assessing Solutions That Did Not Work

- *What have you tried to solve this problem?*

Most clients respond with a list of things that have not worked. If they need more prompting, counselors may ask the following:

- *I am guessing you have tried to solve this problem (address this issue) on your own and that some things were not as successful as you had hoped. What have you tried that did* not *work?*

Previous Solutions That Did *Work/Unique Outcomes*

Assessing previous solutions that helped is much harder because most clients are less aware of when the problem is not a problem and how they have kept things from getting worse. Solution-focused (de Shazer, 1988; O'Hanlon & Weiner-Davis, 1989) and narrative counselors (Freedman & Combs, 1996; White & Epston, 1990) have developed most of the assessment strategies for assessing what has worked.

Questions for Assessing Solutions and Unique Outcomes

- *What keeps this problem from being worse than it is right now?*
- *Is there any solution you have tried that worked for a while? Or made things slightly better?*
- *Are there times or places when the problem is less of a problem or when the problem is not a problem?*
- *Have you ever been able to respond to the problem so that it is less of a problem or less severe?*
- *Does this problem occur in all places with all people, or is it better in certain contexts?*

These questions generally require more thought and reflection on the part of the client and often require more follow-up questions on the part of the counselor. The answers to these questions often provide invaluable clues as to how best to proceed and intervene in counseling.

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Miracle Question

The original solution-generating question, the *miracle question* serves to both (a) conceptualize and assess and (b) set goals in solution-based counseling. The question goes as follows:

> *Miracle question:* Imagine that you go home tonight, and during the middle of the night a miracle happens: *All the problems you came here to resolve* are miraculously resolved. However, when you wake up, you have no idea a miracle has occurred. What are some of the first things you would notice that would be different? How would you know that the problems that brought you here were resolved?

The key to successfully using this question to conceptualize the case involves (a) emphasizing that the miracle isn't just any old miracle but that it specifically resolves *problems that brought you here today*, and (b) getting specific, behavioral descriptions of what is different (not what the client wouldn't be doing or feeling). When delivered well, this single intervention can generate just about all of your client goals for treatment. For example, when working with a client who reports feeling depressed, a properly delivered miracle question would uncover goal-informing information, such as he would (a) wake up excited about the day, (b) go for a run, (c) hug and kiss his wife, (d) read a passage from his favorite Rumi book, and (e) arrive at work on time and warmly greet coworkers.

Narrative, Dominant Discourses, and Diversity

Dominant Discourses informing definition of problem:

- *Ethnic, Class and Religious Discourses: How do key cultural discourses inform what is perceived as a problem and the possible solutions?* _____
- *Gender and Sexuality Discourses: How do the gender/sexual discourses inform what is perceived as a problem and the possible solutions?* _____
- *Community, School, and Extended Family Discourses: How do other important community discourses inform what is perceived as a problem and the possible solutions?* _____

Identity Narratives: *How has the problem shaped each client's identity?* _____

_____

Local or Preferred Discourses: What is the client's preferred identity narrative and/or narrative about the problem? Are there local (alternative) discourses about the problem that are preferred? _____

_____

_____

Assessing dominant social discourses in which a client's problems are embedded often creates a broader and new perspective on a client's situation (Freedman & Combs, 1996; White & Epston, 1990). I frequently find that this broader perspective helps me to feel more freedom and possibility, increasing my emotional attunement to clients and allowing me to be more creative in my work. For example, when I view a client's reported "anxiety" as part of a larger discourse in which the client feels powerless, such as being a sexual minority, I begin to see the anxiety as part of this larger social dance. I also see how it is possible for this person to put less "faith," weight, or credence to the dominant discourse and to generate new stories about what is "normal" sexual behavior and what is not. By discussing the difficulty in concretely defining what is "normal" sexual behavior and what is not, the client and I can begin to explore the

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truths that this person has experienced. We join in an exploratory process that offers new ways for the client to understand the anxiety as well as his or her identity.

Common dominant discourses or broader narratives that inform clients' lives include the following:

- Culture, race, ethnicity, and immigration
- Gender, sexual orientation, and sexual preferences
- Family of origin experiences, such as alcoholism, sexual abuse, adoption, and so on
- Stories of divorce, death, and loss of significant relationships
- Wealth, poverty, power, and fame
- Small-town, urban, and regional discourses
- Health, illness, body image, and so on

Identity Narratives

When a client comes for counseling, the problem discourse has almost always become a significant part of one or more person's *identity narrative*, the story people tell themselves as to who they are. For example, a child having problems in school may begin to think, "I am stupid," while his mother may also be feeling like, "I have failed as a mother" because of her child's academic performance. Obviously, these negative sweeping judgments of a person's value or ability need to be addressed in counseling. Assessing these early in the process is useful to understand how to engage and motivate each person.

Local and Preferred Discourses

Local discourses are the stories that occur at the "local" (as opposed to dominant societal) level (Anderson, 1997). These narratives often are built on personal beliefs and unique interpretations and often contradict or significantly modify dominant discourses. Although it is theoretically possible for local discourses to contribute to the problem (e.g., having more oppressive versions of dominant discourses), they are most often a significant source of motivation, energy, and hope for addressing problems. Most often, local discourses are a person's "personal truth" that they have been hiding or are ashamed of because of anticipated disapproval from others. Local discourses can address common subculture values, such as valuing certain religious or sexual practices, or highly unique to an individual, such as wanting to sell everything and travel the world. Local discourses are often the source of *preferred discourses* in narrative counseling (Freedman & Combs, 1996), which are the preferred version of one's life and identity that serve as the goal in narrative counseling.

Case Conceptualization, Diversity, and Sameness

Just in case you were beginning to feel like you finally understood something about case conceptualization, let me throw a wrench or two into the mix: diversity and sameness. The problem with case conceptualization and assessments in general (this applies to prior chapters as well) is that there are no objective standards against which a person can be measured for "healthy boundaries," "logical thinking," or "clear communication." Healthy, emotionally engaged boundaries look quite different in a Mexican American family and an Asian American family. In fact, problematic boundaries in a Mexican American family (e.g., cool, disengaged) may look *more like* healthy (e.g., quietly respectful) than problem boundaries (e.g., overly involved) in an Asian American family. Thus, counselors cannot rely simply on objective descriptions of behavior in assessment. Instead, counselors must consider the broader culture norms, which may include *more than one* set of ethnic norms as well as local neighborhood culture, school contexts, sexual orientation subculture, religious communities, and so on. Although you will undoubtedly take a course on cultural issues that will go into more depth on this topic and will read that professional codes of ethics require respecting diversity, it takes working with a diverse range

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of individuals and families and a willingness to learn from them to cultivate a meaningful sense of cultural sensitivity. I believe this to be a lifelong journey.

Ironically, I have found that new counselors in training today sometimes have the most difficulty accepting diversity in clients from *within* their culture of origin or who are in some ways similar to the counselor. The more similar clients are to us, the more we expect them to share our values and behavioral norms, making us more likely to have a low threshold for differentness. For example, middle-class Caucasian counselors often expect middle-class Caucasian clients to have particular values toward emotional expression, marital arrangements, extended family, and parent–child relationships and may be quick to encourage particular systems of values, namely, their own. Thus, whether working with someone very similar or very different from yourself, counselors need to *slowly* assess and evaluate, always considering clients' broader sociocultural context and norms. Counselors who excel in conceptualization and assessment approach these tasks with profound humility and a continual willingness to learn.

This End Is Just the Beginning

You have just traversed the bridge across the Grand Canyon of counseling. I hope you have that exhausted but exhilarating feeling that comes with great travel adventures. Not only have you been on a grand tour of the major counseling and psychotherapy theories, which is a lot in itself, you have also learned perhaps the most critical of documentation skills: case conceptualization and treatment planning. If you are new to the field, by embarking on this admittedly challenging expedition early in your career, you have greatly accelerated your journey to becoming a competent counselor—by establishing a solid foundation and framework upon which to build—as you move forward. For those who are more established, I am hoping that many pieces have fallen into place that help take your practice to the next level.

In any case, I hope this is not the only time you read this book. Although this book is part textbook, it is more fundamentally a reference and, I hope, a career-long companion for you. Each theory covered in this book is rich with insights into the human experience and how counselors can help people meet the challenges in their lives with grace and courage and prevent further crises from arising. For better or worse, counselors and psychotherapists are never done learning, because new theories are developed each year and theories from over a hundred years ago still can assist us in our work. Each time you reread a section on one of these theories, I assure you that you will have new aha moments that make a client's situation, your own life, or the counseling profession make more sense. In fact, this book gets better and better each time you read it because you are able to conceptualize the material at deeper and more profound levels because of your practice in between. Thus, this is not an ending but rather the beginning of the next stage of the journey to becoming a competent counselor.

Questions for Personal Reflection and Class Discussion

1. Which area of the cross-theory case conceptualization seems MOST useful to you? Why?
2. Which area of the cross-theory case conceptualization seems LEAST useful to you? Why?
3. Which area of the cross-theory case conceptualization was the most difficult to complete? What was challenging?
4. What elements seemed to touch on the same dynamic with different language?
5. What elements would you probably not consider unless you had to fill out this form?

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Online Resource

Associations

Family History Maker: U.S. Department of Health and Human Services www.hhs.gov/familyhistory

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Case Conceptualization Form

DIGITAL VERSIONS OF THIS FORM ARE AVAILABLE ON THE TEXTBOOK WEBSITE

Counseling Case Conceptualization

Date: _____ **Clinician:** _____ **Client/Case #:** _____

I. Introduction to Client

Identify primary client and significant others

Client

Select Client Type Age: _____ Select Ethnicity Select Relational Status Occupation/Grade: _____ Other: _____

Significant Others

Select Person Age: _____ Select Ethnicity Select Relational Status Occupation/Grade: _____ Other:_____

Select Person Age: _____ Select Ethnicity Select Relational Status Occupation/Grade: _____ Other:_____

Select Person Age: _____ Select Ethnicity Select Relational Status Occupation/Grade: _____ Other:_____

Select Person Age: _____ Select Ethnicity Select Relational Status Occupation/Grade: _____ Other:_____

Others: _____

II. Presenting Concern(s)

Client Description of Problem(s): _____

_____

_____

Significant Other/Family Description(s) of Problems: _____

_____

_____

Broader System Problem Descriptions: Description of problem from referring party, teachers, relatives, legal system, etc.:

Name: _____

Name: _____

III. Background Information

Trauma/Abuse History (recent and past): _____

_____

(*continued*)

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Substance Use/Abuse (current and past; self, family of origin, significant others): _____

_____

_____

Precipitating Events (recent life changes, first symptoms, stressors, etc.): _____

_____

_____

Related Historical Background (family history, related issues, previous counseling, etc.): _____

_____

_____

IV. Client Strengths and Diversity

Client Strengths

Personal: _____

_____

Relational/Social: _____

_____

Spiritual: _____

_____

Diversity: Resources and Limitations

Identify potential resources and limitations available to clients based on their age, gender, sexual orientation, cultural background, socioeconomic status, religion, regional community, language, family background, family configuration, abilities, etc.

Unique Resources: _____

_____

Potential Limitations: _____

_____

Complete All of the Following Sections for a Complete Case Conceptualization or Specific Sections for Theory-Specific Conceptualization.

V. Psychodynamic Conceptualization

Psychodynamic Defense Mechanisms *Check and describe the 2–4 most commonly used defense mechanisms*

❑ Acting Out: *Describe:* _____

❑ Denial: *Describe:* _____

(*continued*)

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❑ Displacement: *Describe:* _____

❑ Help-rejecting complaining: *Describe:* _____

❑ Humor: *Describe:* _____

❑ Passive Aggression: *Describe:* _____

❑ Projection: *Describe:* _____

❑ Projective Identification: *Describe:* _____

❑ Rationalization: *Describe:* _____

❑ Reaction Formation: *Describe:* _____

❑ Repression: *Describe:* _____

❑ Splitting: *Describe:* _____

❑ Sublimation: *Describe:* _____

❑ Suppression: *Describe:* _____

❑ Other: _____

Object Relational Patterns

Describe relationship with early caregivers in past: _____

_____

_____

Was the attachment with the mother (or equivalent) primarily: ❑ Generally Secure
❑ Anxious and Clingy ❑ Avoidant and Emotionally Distant ❑ Other: _____

Was the attachment with the father (or equivalent) primarily: ❑ Generally Secure
❑ Anxious and Clingy ❑ Avoidant and Emotionally Distant ❑ Other: _____

Describe present relationship with these caregivers: _____

_____

Describe relational patterns with partner and other current relationships: _____

_____

_____

Erickson's Psychosocial Developmental Stage

Describe development at each stage up to current stage

Trust vs. Mistrust (Infant stage): _____

Autonomy vs. Shame and Doubt (Toddler stage): _____

Initiative vs. Guilt (Preschool age): _____

(*continued*)

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Industry vs. Inferiority (School age): _____

Identity vs. Role Confusion (Adolescence): _____

Intimacy vs. Isolation (Young adulthood): _____

Generativity vs. Stagnation (Adulthood): _____

Ego Integrity vs. Despair (Late Adulthood): _____

Adlerian Style of Life Theme

❑ Control: _____

❑ Superiority: _____

❑ Pleasing: _____

❑ Comfort: _____

Basic Mistake Misperceptions: _____

VI. Humanistic-Existential Conceptualization

Expression of Authentic Self

Problems: Are problems perceived as internal or external (caused by others, circumstance, etc.)? ❑ Predominantly internal ❑ Mixed ❑ Predominantly external

Agency and Responsibility: Is self or other discussed as agent of story? Does client take clear responsibility for situation? ❑ Strong sense of agency and responsibility ❑ Agency in some areas ❑ Little agency; frequently blames others/situation ❑ Often feels victimized

Recognition and Expression of Feelings: Are feelings readily recognized, owned, and experienced? ❑ Easily expresses feelings ❑ Identifies feelings with prompting ❑ Difficulty recognizing feelings

Here-and-Now Experiencing: Is the client able to experience full range of feelings as they are happening in the present moment? ❑ Easily experiences emotions in present moment ❑ Experiences some present emotions with assistance ❑ Difficulty with present moment experiencing

Personal Constructs and Facades: Is the client able to recognize and go beyond roles? Is identity rigid or tentatively held? ❑ Tentatively held; able to critique and question ❑ Some awareness of facades and construction of identity ❑ Identity rigidly defined; seems like "fact"

Complexity and Contradictions: Are internal contradictions owned and explored? Is client able to fully engage the complexity of identity and life? ❑ Aware of and resolves contradictions ❑ Some recognition of contradictions ❑ Unaware of internal contradictions

Shoulds: Is client able to question socially imposed shoulds and oughts? Can client balance desire to please others and desire to be authentic? ❑ Able to balance authenticity with social obligation ❑ Identifies tension between social expectations and personal desires ❑ Primarily focuses on external shoulds

List shoulds: _____

Acceptance of Others: Is client able to accept others and modify expectations of others to be more realistic? ❑ Readily accepts others as they are ❑ Recognizes expectations of others are unrealistic but still strong emotional reaction to expectations not being met ❑ Difficulty accepting others as is; always wanting others to change to meet expectations

Trust of Self: Is client able to trust self as process (rather than a stabile object)? ❑ Able to trust and express authentic self ❑ Trust of self in certain contexts ❑ Difficulty trusting self in most contexts

(*continued*)

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Existential Analysis

Sources of Life Meaning (as described or demonstrated by client): _____

_____

_____

General Themes of Life Meaning: ❑ Personal achievement/work ❑ Significant other ❑ Children ❑ Family of origin ❑ Social cause/contributing to others ❑ Religion/spirituality ❑ Other: _____

Satisfaction with and clarity on life direction:

❑ Clear sense of meaning that creates resilience in difficult times

❑ Current problems require making choices related to life direction

❑ Minimally satisfied with current life direction; wants more from life

❑ Has reflected little on life direction up to this point; living according to life plan defined by someone/something else

❑ Other: _____

Gestalt Contact Boundary Disturbances

❑ *Desensitization:* Failing to notice problems

❑ *Introjection*: Take in others' views whole and unedited

❑ *Projection*: Assign undesired parts of self to others

❑ *Retroflection*: Direct action to self rather than other

❑ *Deflection*: Avoid direct contact with another or self

❑ *Egotism:* Not allowing outside to influence self

❑ *Confluence*: Agree with another to extent that boundary blurred

Describe: _____

_____

VII. Cognitive-Behavioral Conceptualization

Baseline of Symptomatic Behavior

Symptom #1 (behavioral description): _____

Frequency: _____

Duration: _____

Context(s): _____

Events Before: _____

Events After: _____

(*continued*)

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Symptom #2 (behavioral description): _____

Frequency: _____

Duration: _____

Context(s): _____

Events Before: _____

Events After: _____

A-B-C Analysis of Irrational Beliefs

Activating Event ("Problem"): _____

Consequence (Mood, behavior, etc.): _____

Mediating Beliefs (Unhelpful beliefs about event that result in C): _____

1. _____

2. _____

3. _____

Beck's Schema Analysis

Identify frequently used cognitive schemas:

❑ *Arbitrary inference:* _____

❑ *Selective abstraction:* _____

❑ *Overgeneralization:* _____

❑ *Magnification/Minimization:* _____

❑ *Personalization:* _____

❑ *Absolutist/dichotomous thinking:* _____

❑ *Mislabeling:* _____

❑ *Mindreading:* _____

VIII. Family Systems Conceptualization

Family Life Cycle Stage

❑ Single adult ❑ Marriage ❑ Family with Young Children ❑ Family with Adolescent Children ❑ Launching Children ❑ Later Life

Describe struggles with mastering developmental tasks in one of these stages: _____

_____

Boundaries with

Parents ❑ Enmeshed ❑ Clear ❑ Disengaged ❑ NA: *Describe:* _____

Significant Other ❑ Enmeshed ❑ Clear ❑ Disengaged ❑ NA: *Describe:* _____

(*continued*)

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Children ❑ Enmeshed ❑ Clear ❑ Disengaged ❑ NA: *Describe:* _____

Extended Family ❑ Enmeshed ❑ Clear ❑ Disengaged ❑ NA: *Describe:* _____

Other: Name ❑ Enmeshed ❑ Clear ❑ Disengaged ❑ NA: *Describe:* _____

Typical style for regulating closeness and distance with others: _____

_____

_____

Triangles/Coalitions

❑ Coalition in family of origin: *Describe:* _____

❑ Coalitions related to significant other: *Describe:* _____

❑ Other coalitions: _____

Hierarchy between Self and Parent/Child ❑ NA

With own children ❑ Effective ❑ Rigid ❑ Permissive

With parents (for child/young adult) ❑ Effective ❑ Rigid ❑ Permissive

Complementary Patterns with Name:

❑ Pursuer/distancer ❑ Over-/underfunctioner ❑ Emotional/logical ❑ Good/bad parent ❑ Other: *Describe*

Example of complementary pattern: _____

Intergenerational Patterns

Substance/Alcohol Abuse: ❑ NA ❑ History: _____

Sexual/Physical/Emotional Abuse: ❑ NA ❑ History: _____

Parent/Child Relations: ❑ NA ❑ History: _____

Physical/Mental Disorders: ❑ NA ❑ History: _____

Family strengths: *Describe*: _____

IX. Solution-Based and Cultural Discourse Conceptualization (Postmodern)

Solutions and Unique Outcomes

Attempted Solutions that DIDN'T or DON'T work:

1. _____

2. _____

3. _____

(*continued*)

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Exceptions and Unique Outcomes: Times, places, relationships, contexts, etc. when problem is less of a problem; behaviors that seem to make things even slightly better:

1. _____

2. _____

3. _____

Miracle Question Answer: If the problem were to be resolved overnight, what would client be doing differently the next day? (Describe in terms of doing X rather than not doing Y.)

1. _____

2. _____

3. _____

Dominant Discourses informing definition of problem:

- *Ethnic, Class and Religious Discourses: How do key cultural discourses inform what is perceived as a problem and the possible solutions?* _____

  _____

- *Gender and Sexuality Discourses: How do the gender/sexual discourses inform what is perceived as a problem and the possible solutions?* _____

  _____

- *Community, School, and Extended Family Discourses: How do other important community discourses inform what is perceived as a problem and the possible solutions?* _____

  _____

Identity Narratives: *How has the problem shaped each client's identity?* _____

Local or Preferred Discourses: What is the client's preferred identity narrative and/or narrative about the problem? Are there local (alternative) discourses about the problem that are preferred? _____

_____

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APPENDIX

A

Treatment Plan Rubric

Note: The sample rubric below is correlated to the CACREP Clinical Mental Health Counseling competencies. On the textbook websites at www.Cengage.com and the www.masteringcompetencies.com, instructors and students will find additional rubrics correlated to all the major mental health competencies, including the following:

- Each of the 2009 CACREP areas of specialty: addictions, career, clinical mental health, marriage, couple, and family, school, and student affairs and college counseling.
- The marriage and family therapy (AAMFT) Core Competencies
- The social work (CSWE) competencies
- 2011 psychology competency benchmarks

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Date: _____

Student: _____

Evaluator: _____

Level of Clinical Training:

❑ Pre-clinical training; coursework only
❑ 0–12 months
❑ 12–24 months
❑ 2+ years

Rating Scale

5 = Exceptional: Skills and understanding significantly beyond developmental level
4 = Outstanding: Strong mastery of skills and thorough understanding of concepts
3 = Mastered Basic Skills at Developmental Level: Understanding of concepts/skills evident
2 = Developing: Minor conceptual and skill errors; in process of developing
1 = Deficits: Significant remediation needed; deficits in knowledge/skills
NA = Not Applicable: Unable to measure with given data (do not use to indicate deficit)

	5	4	3	2	1	Comp	Score
Theory-Specific Case Conceptualization (Optional)	Sophisticated and subtle case conceptualization narrative using theory-specific elements; integrates diversity, trauma, and substance abuse, and diversity issues; unique and specific.	Thoughtful and specific case conceptualization narrative that includes discussion of major theory-specific elements; addresses diversity and unique client needs.	Case conceptualization narrative uses theory-specific concepts to address salient client issues.	Inconsistent or incorrect use of theory-specific conceptualization elements. Ignores subtle diversity issues.	Significant problems with case conceptualization, such as misunderstanding key theoretical concepts, mixing theories, missing significant diversity issues, etc.	A5 C8 D1 D2 D5 E1 E2 G1	❑ NA
Choice of Theory (if applicable)	Choice of theory demonstrates sophisticated understanding of the evidence base and best approaches for presenting problem; adapts choice for age, culture, ability, trauma, values, etc.	Choice of theory demonstrates thoughtful understanding of presenting problem; good choice for age, culture, ability, values, trauma, etc.	Choice of theory is appropriate for presenting problem.	Minor problem with chosen theory for client; no particular attention to age, culture, ability, values, etc.	Inappropriate choice of theory given problem, research, age, culture, ability, values, etc.	A1 A5 C8 E3 I3 J1 K2	❑ NA
Initial Phase Task: Relationship	Sophisticated application of theory's specific form of counseling relationship; relates directly to specifics of case and diversity issues.	Identifies at least one theory-specific technique for forming relationship and uniquely applies to client needs/diversity issues; more detailed than template in the book.	Identifies an effective technique from theory for forming a counseling relationship.	Minor theoretical inconsistencies related to counseling relationship and/or no specific application to case.	Significant problems or theoretical inconsistencies addressing counseling relationship.	A5	❑ NA

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Initial Phase Task: Assessment	Sophisticated use of theory-specific assessment; uniquely applied to case; adapts for age, culture, education, service context.	At least one theory-specific assessment; proposed assessments appropriate for age, culture, education, etc.; more detailed than template in the book.	Theoretically consistent assessment techniques that are appropriate for case.	Minor problems or theoretical inconsistencies with proposed assessments.	Significant problems with proposed assessment; does not address critical diversity issues, such as age, culture, education, language, etc.	C7 D1 H1 H4	❑ NA
Initial Phase Client Goal	Sophisticated, well-chosen initial goal that address specific, immediate client needs or crisis; goals clearly prioritized based on research, treatment model, diversity issues, and client needs.	Well-chosen initial goal that address immediate client needs; more detailed than template in the book.	Appropriate initial goal that address immediate client needs.	Minor problems with initial goal; may not be prioritized correctly or specific enough.	Initial goal inappropriate; misses immediate and/or crisis issues.	A5 D1 D2 J2	❑ NA
Initial Phase Interventions	Sophisticated choice of interventions appropriate for initial stage of counseling; theory-specific and tailored to client and diversity needs.	Thoughtful choice of interventions; theory-specific; more detailed than template in the book.	Appropriate choice of interventions for goal that generally fit with theory.	Minor problems or vague interventions; may not be a good fit for theory.	Significant problems with initial interventions; theoretically inappropriate or poor fit for client.	A5 C1 F3	❑ NA
Working Phase Task: Monitor Alliance	Theory-specific handling of diversity issues and client needs for monitoring alliance; specific and realistic.	Meaningful attention to diversity and client needs for monitoring the alliance; more detailed than template in the book.	Identifies appropriate intervention for monitoring alliance.	Minor problems with plans for monitoring alliance.	Does not provide appropriate and/or or any means for monitoring alliance.	D1 I3	❑ NA
Working Phase Client Goals	2-3 easily measured and theory-specific goals that skillfully address all issues identified in case conceptualization by identifying client's core issues; goals are unique, specific, and tailored to client situation and diversity needs.	2-3 measurable goals that target assessed issues in case conceptualization; goals consistent with chosen theory; attention to diversity; more detailed than template in the book.	2-3 goals that target major assessed problems; reflect basic understanding of content vs. process; appropriate for client.	Vague goals and/or theoretically inconsistent yet appropriate goals. No clear distinction between content and process.	Inappropriate goals and/or unclear goals; goals outside scope of competence or practice.	A5 D1 D2 J2	❑ NA

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	5	4	3	2	1	Comp	Score
Working Phase Interventions	Carefully crafted interventions that support goal achievement; theory-specific and tailored to client; clear and realistic plan of how to achieve goal; interventions include specific examples (e.g., quotes, etc.).	2 detailed interventions for each goal; theory-specific and applied to client; more detailed than template in the book.	1-2 appropriate interventions for each goal that are generally consistent with theory.	Suggested interventions do not support stated goal; theoretically inconsistent.	Poor choice of intervention given stated goals. Poor description of intervention.	A5 C1 F3	❑ NA
Closing Phase Task: Aftercare Plan	Sophisticated and detailed approach to termination and aftercare plans; theory specific and tailored to fit unique client needs/diversity.	Thoughtful approach to termination and aftercare plans that fit with theory; more detailed than template in the book.	Appropriate termination and aftercare plans; broadly reflects theory and client needs.	Minor problems with closing plan; unrealistic or inappropriately adapted for client.	Significant problems with closing plan; unrealistic or inappropriately adapted for client.	C5 D3	❑ NA
Closing Phase Client Goals	Targets theory's long-term goals if appropriate (i.e., definition of health) and client's goals; detailed, clear and specific; promotes overall personal and relational wellness; addresses diversity/client specific.	1-2 goals appropriate for theory in late phase that are specific to client; promotes long-term wellness; more detailed than template in the book.	1-2 goals that address long-term goals related to client's presenting concerns.	Minor problems with closing goals; does not attend to theory's model of health.	Significant problems with closing goals; inappropriate or unrealistic.	A5 D1 D2 D3 J2	❑ NA
Closing Phase Interventions	Sophisticated interventions that support sustained gains; theory-specific and tailored to client; clear and realistic interventions for long-term wellness; interventions include specific examples.	2 interventions that support goal achievement; specific and unique; theory-specific; more detailed than template in the book.	Appropriate interventions that support goal; consistent with theory.	Suggested interventions do not support stated goal; theoretically inconsistent; vague examples of specific interventions.	Poor choice of intervention given stated goals. Poor description of intervention.	A5 C1 F3	❑ NA
Overall Understanding of Theory and Technique	Sophisticated understanding of theory and techniques; plan highly consistent with theory yet uniquely adapted for cultural/context factors; demonstrates original thinking.	Clear understanding of theory and techniques; interventions consistent with theory and appropriate for cultural/context factors; goes beyond template in the book.	Solid understanding of theories and techniques; closely follows template; interventions generally consistent with theory and cultural/context factors.	Some problems with understanding of theory and techniques; interventions often not consistent with theory.	Significant problems with understanding of theories and techniques; interventions generally not consistent with theory.	A5 D2 F3	❑ NA

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Overall Plan	Sophisticated plan that reveals depth of understanding of theory and ability to creatively meet client and diversity needs and goals. Extensive detail with some specific examples of interventions (e.g., quotes, etc.).	Thoughtful plan that goes beyond template in the book to reveal unique application of theory; plan addresses most areas related to presenting problem using theory.	Theory-specific plan that closely models template; effectively addresses client's presenting problem.	Minor problems with plan, such as not all aspects fitting with theory, not addressing presenting problems, etc.	Significant problems with plan, such as numerous theoretical inconsistencies, missing key aspects of presenting problem, etc.	C8 D7 G1	❑ NA
Comments:							

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APPENDIX

B

Comprehensive Case Conceptualization Rubric

Note: The sample rubric below is correlated to the CACREP Clinical Mental Health Counseling competencies. On the textbook websites at www.Cengage.com and the www.masteringcompetencies.com, instructors and students will find additional rubrics correlated to all the major mental health competencies, including the following:

- Each of the 2009 CACREP areas of specialty: addictions, career, clinical mental health, marriage, couple, and family, school, and student affairs and college counseling.
- The marriage and family therapy (AAMFT) Core Competencies
- The social work (CSWE) competencies
- 2011 psychology competency benchmarks

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Date: _____

Student: _____

Evaluator: _____

Level of Clinical Training:

❑ Pre-clinical training; coursework only
❑ 0–12 months
❑ 12–24 months
❑ 2+ years

Rating Scale

5 = Exceptional: Skills and understanding significantly beyond developmental level
4 = Outstanding: Strong mastery of skills and thorough understanding of concepts
3 = Mastered Basic Skills at Developmental Level: Understanding of concepts/skills evident
2 = Developing: Minor conceptual and skill errors; in process of developing
1 = Deficits: Significant remediation needed; deficits in knowledge/skills
NA = Not Applicable: Unable to measure with given data (do not use to indicate deficit)

	5	4	3	2	1	Comp	Score
Introduction	Detailed yet succinct intro that identifies client, age, ethnicity, occupation, grade, etc. Descriptions clearly set context for understanding problem.	Complete intro that identifies client, age, ethnicity, occupation, grade, etc.	Basic information related to age, ethnicity, occupation, grade, etc. included.	Missing 1-2 identifiers.	Missing, incorrect or significant problem with identifiers and/or significant involved parties.	C7 H2	❑ NA
Presenting Concern	Description of problem provides sophisticated depiction of all stakeholders' views; word choice conveys empathy with each perspective; descriptions clearly contribute to coherent conceptualization.	Description of problem provides useful description of all stakeholders' views; word choice conveys respect for perspectives.	Includes description of problem for each person and key stakeholders.	Minor problems or lack of clarity with problem descriptions; missing stakeholders.	Significant problems with problem descriptions; missing key perspectives; incorrect characterization.	C7 H2	❑ NA
Background Information	Includes detailed yet succinct description of recent and past events and traumas. Selected information helps develop coherent conceptualization.	Includes useful summary of recent and past events and traumas with time frames.	Includes summary of key recent and past events and traumas.	Insufficient, minimal or missing background information.	Significant information missing; unable to identify significant events.	A9 H2 H4	❑ NA

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Client Strengths & Diversity	Insightful identification of strengths; able to identify subtle diversity resources and limitations and how these may impact counseling process.	Clear articulation of useful strengths; able to identify several key resources and limitations related to diversity, oppression, and marginalization.	Identifies several strengths as well as significant resources and limitations related to diversity.	Underdeveloped description of strengths. Missed one or more significant diversity limitation.	Significant problems identifying clinically relevant strengths and/or diversity issues.	D2 D3 E1 E2	❑ NA
Psycho-dynamic and Adlerian	Sophisticated analysis that coherently and succinctly relates defense mechanisms, object relation patterns, developmental stages and style of life themes. Clear sense of core dynamics emerges.	Thoughtful and coherent descriptions of defense mechanisms, object relation patterns, developmental stages and style of life themes.	Identifies key issues in defense mechanisms, object relation patterns, developmental stages and style of life themes.	Minor errors or inconsistencies in descriptions of defense mechanisms, object relation patterns, developmental stages and/or style of life themes.	Incorrect, poor characterization of defense mechanisms, object relation patterns, developmental stages and style of life themes.	A5	❑ NA
Humanistic-Existential	Sophisticated analysis that coherently and succinctly relates expressions of self, existential issues, and boundary disturbances. Clear sense of core issues developed.	Thoughtful and coherent descriptions of expressions of self, existential issues, and boundary disturbances.	Identifies key issues in expressions of self, existential issues, and boundary disturbances.	Minor errors or inconsistencies in descriptions of expressions of self, existential issues, and boundary disturbances.	Significant problems with expressions of self, existential issues, and boundary disturbances; misidentified issues.	A5	❑ NA
Cognitive-Behavioral	Sophisticated analysis that coherently and succinctly relates behavioral analysis, ABC analysis, and schemas. Clear sense of core themes emerges.	Thoughtful and coherent descriptions of behavioral analysis, ABC analysis, and schemas.	Identifies key issues in behavioral analysis, ABC analysis, and schemas.	Minor problems conceptualizing behavioral analysis, ABC analysis, and schemas.	Significant problems identifying behavioral analysis, ABC analysis, and schemas.	A5	❑ NA
Family Systems	Sophisticated analysis that coherently and succinctly relates assessment of family life cycle, family structure, and intergenerational patterns. Clear depiction of how family patterns relate to problem.	Thoughtful and coherent descriptions of family life cycle, family structure, and intergenerational patterns.	Identifies key issues in family life cycle, family structure, and intergenerational patterns.	Misses minor issues in family life cycle, family structure, and intergenerational patterns.	Misses significant issues related to family life cycle, family structure, and intergenerational patterns.	A5 C8	❑ NA

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	5	4	3	2	1	Comp	Score
Solution-Focused	Sophisticated analysis that reveals creativity in identifying solutions that did and did not work; behavioral, positively stated, and easily implementable answers to miracle question.	Able to identified several useful exceptions to the problem; answers to miracle question behavioral and positively stated.	Provides examples of solutions that did and did not work; behavioral answers to miracle question.	Solutions and miracle question not approached from a strengths perspective; lack usefulness and practicality.	Significant problems with assessment of strengths and/or does not demonstrate understanding of miracle question.	A5	❑ NA
Narrative, Dominant Discourses, and Diversity	Thoughtfully identifies effect of dominant discourses in client's life; able to meaningfully identify several cultural, SES, gender, and larger social discourse issues and outline how these intersect. Addresses oppression and marginalization.	Detailed description of the effect of dominant discourses in client's life; able to meaningfully identify at least two cultural, SES, gender, and larger social discourse issues.	Clear description of key diversity issues and broader social discourses affecting client and experience of problem.	Minor issues with identification of social and dominant discourses.	Misses one or more significant diversity issue and/or unable to usefully identify its effect on the client's life.	A5 D2 E1 E2 E5	❑ NA
Overall Conceptualization	All elements of case conceptualization clearly fit to create a unified understanding to guide counseling process. Sophisticated conceptualization that identifies subtle issues.	Well developed conceptualization that enables reader to a have a clear sense of client and core issues.	Provides a useful description of key issues for developing treatment plan. Few if any inconsistencies.	Several minor inconsistencies that are not clearly reconciled.	Significant problems with conceptualization, such as irreconcilable discrepancies or missing key issues.	A5 C7 D7 F3 H1	❑ NA
Comments:							

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